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Health and Medical Care

A People's Movement

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PHM | SR9-51 (R97)

N. H. Antia
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frch

Foundation for Research in Community Health

CPHE

What is FRCH?

The Foundation was established in 1975 as a non-profit voluntary organization to promote the concept of health care rather than the mere care of illness. This entails the study of health in its wider perspective, in order to improve the health of our people. The emphasis is on the problems of the underprivileged sections of our society, especially women and children.

Our staff from various disciplines are engaged in conducting both conceptual research as well as field studies into the problems faced in achieving Health for All. This is to help in devising alternative models of health and medical care in keeping with the social, economic and cultural reality of our country. The aim is to influence government policy and sensitise the people at all levels to the problems and possibility of achieving good health at affordable cost.

FRCH believes that health is a reflection of the overall quality of life in fact 80% of the diseases in India are the diseases of poverty and true health can exist only when there is a positive improvement in the socio-economic scenario of the country. This can only be achieved through the people's own efforts. Hence, FRCH aims to create a People's Health Movement by demystifying medicine and increasing public awareness on health, especially at the grassroots, and by strengthening the age old health culture of our people based on our own systems of health and medical care. This is to be achieved, by publishing and disseminating information on all aspects of health and related subjects, and also by conducting par ...mmunity.

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Dedication

This book is dedicated to the memory of the late J. P. Naik and his belief in people-based alternatives
and
to the women of Bharat who have demonstrated the fulfilment of his vision.

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Dear Noshir,

I seek your indulgence and request for a little more time for me to write a suitable foreword to your excellent monograph. I hope you will be able to grant this request.

With kind regards,

Yours sincerely,

V. RAMALINGASWAMI

Abbreviations

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
CHC	Community Health Centre
CHF	Community Health Functionary
CHO	Chief Health Officer
CHV	Community Health Visitor
CHW	Community Health Workers
DOT	Direct Observed Treatment
EPI	Extended Programme of Immunisation
GDMO	General Duty Medical Officer
GDO	General Duty Officer
GOI	Government of India
ICMR	Indian Council of Medical Research
ICSSR	Indian Council of Social Science and Research
IGNOU	Indira Gandhi National Open University
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ISM&H	Indian Systems of Medicine and Homeopathy
MCH	Maternal and Child Health
MOHFW	Ministry of Health and Family Welfare
MPW	Multi Purpose Workers
PHC	Primary Health Centre
PSM	Preventive and Social Medicine
RCH	Reproductive and Child Health
SAP	Structural Adjustment Policy
SRU	Satellite Referral Unit
TTC	Taluka Training Centre
UNICEF	United Nations International Children's Educational Fund
USAID	United States Agency for International Development
VHF	Village Health Functionary
WHO	World Health Organisation

Part I

Health Services in India

1

Why one more book on health ?

Considering the plethora of books on health and the innumerable reports on it by various committees during the last few decades, we the authors owe it to the general public and the readers of this book to explain why one more book on health was considered necessary. in this Introduction we explain our reasons.

The Indian systems of Ayurveda and Yoga have emphasized the maintenance of health rather than the mere treatment of disease. Their holistic approach is concerned not only with the well being of the physical body but also of the mind and considers the human being as a part of nature. As such health is considered in a larger philosophical and even a spiritual than a mere medical concept. This has been integrated into the daily life of our people as part of their social and religious practices. The acceptance of the ageing process with grace and the inevitability of death also helps to sustain the mental well being of our people.

India has also incorporated several foreign systems of medicine like Unani, Allopathy and Homeopathy which are largely medically oriented. Though the various systems unfortunately tend to be practiced in isolation by their practitioners they are highly complementary eg. allopathy for communicable diseases and Ayurveda and Yoga for diseases of ageing and lifestyle.

Mahatma Gandhi, the Father of the Nation, advocated a decentralised people-based form of rural development based on the values, traditions and practices of our civilization including those in health. He advocated health as a way of life and even experimented with naturopathy. His stress was on caring rather than mere curing, utilising simple non-formal methods and practices for both education and health at the village level.

Independence offered us the opportunity to integrate the best of all systems in order to provide an effective, affordable and easily accessible health and medical care to all our citizens in a socially acceptable manner. The Primary Health Care concept located within the community and involving it in its own health as advocated by the Bhore Committee's report which was the model accepted for Post Independence India provided a suitable strategy to achieve this.

Post-Independence development in India however has been based almost entirely on the urban industrial model of the West, neglecting Gandhiji's rural agro-industrial model. In the field of health Western science has not only dominated our health and medical scene but has overshadowed and suppressed all other systems including our own.

The reemergence on a large scale of poverty-induced diseases like tuberculosis is a matter for concern. Together with the increase in the cost of essential drugs this will deliver the coup de grace to the 36% who continue to live below the poverty line even 50 years after Independence. (GOI, 2000.)

Alternative policies and strategies are therefore required if Health For All is to become a reality. Mere tinkering with the existing systems will not do.

The 1981 ICSSR/ICMR report 'Health for All: An Alternative Strategy' stated that 95% of all health care. up to the level of the broad based specialist. can be most effectively carried out within the 100,000 population taluka/block level. Such a decentralised service would leave few problems requiring expensive sophisticated care at the remote district and tertiary levels. The alternative strategy suggested a harmonious balance between health functionaries at the grassroot level and health professionals possessing a higher level of technical competence and expertise.

It stated that Health is a function not only of medical care but even more of the overall integrated development of society - cultural, economic, educational, social and political. Health also depends on a number of supportive services - nutrition, education of the female, improvement in water, sanitation and environment.

The 1981 report also clearly stated that such a decentralised people-based, people-controlled and people-operated system which takes care of both the medical as well as the non-medical aspects of health can only be possible under the hitherto ignored Peoples Sector namely Panchayati Raj. **It needs to be emphasized however that health is the responsibility of the individual, family and local community and Panchayati Raj is an enabling provision which individuals and communities can use for achieving the same.**

The alternative strategy (1981 report) was reiterated in our National Health Policy of 1983 and the Rockefeller report, 'Good Health at Low Cost' in 1985. This report states that the major portion of all preventive, promotive and curative care is best undertaken by the people within the village itself, with local women trained to deal with problems specific to their own village. Such decentralized village level health care can be successful if supported by the community and a simple yet effective graded locally based referral system upto an efficient People's Health, Hospital and Training institution at the Block/Taluka level.

The knowledge and care of not only the common self limiting conditions, but also of the technology even for the prevention, treatment and control of the major causes of morbidity and mortality like ARI (acute respiratory tract infection), water-borne diseases, malaria, tuberculosis and leprosy is remarkably simple, effective, safe and cheap. The village health functionary can be taught to detect these diseases in the early stages and if necessary after confirmation of diagnosis, ensure continuity of the recommended treatment. They can refer problems beyond their knowledge, skills and facilities to the supporting professional service and facilities at the Taluka/Block.

Now that Panchayati Raj has been constitutionally ordained and has become operational in several parts of the country, this book which is an extension of the ICSSR-ICMR report hopes to provide a more detailed account of the People's Model of Health and Medical Care. The people's model is based within our people's own culture and utilises all avenues and systems of appropriate health and medical care in an integrated and holistic manner. This book also takes into consideration the changes that have occurred in the intervening 19 years such as the availability of doctors and specialists at the taluka though not at the Village PHC. People all over the world are in search of an alternative to the present system which overmedicates the rich, pauperizes the middle class and diverts the limited resources of the poor from food to medicines and doctors.

Part I of this book traces briefly the history of health and medical care from the

Pre-British and British days to the post-Independence and present health scene. We hope that this will enable the reader to understand the historic reasons, the compulsions and pressures that have perpetuated a system, even after Independence, where health is denied to the majority of our people and illness converted into a lucrative business and industry. It is the people themselves who will have to undertake the struggle for their own health and medical care since this cannot be 'delivered' to them. They have to realize that many of the health as well as medical problems can be solved effectively by their own health functionaries since they require high social skills but relatively simple technology; and yet a few require professional skills of a doctor or nurse. Hence this requires a graded referral service from the village to the taluka/block Health and Hospital complex with an associated training wing. The two-year trained village Sahyogini provides the crucial link between the village and the taluka complex.

Part II describes the emergence of a new phase in the development of our nation. Panchayati Raj has taken the message to the grassroots and provides constitutional authority, power and responsibility to play an active role in self-governance. The 29 subjects allocated to them under Schedule 11 of the 73rd Amendment of the Constitution which provides control over most activities that concern their day to day life and development includes health. The second half of the book demonstrates that even an over-mystified subject like health and medical care lends itself admirably to decentralised functioning in the Community Health Care System. It describes how almost all health as well as most medical functions can be carried out effectively at each level. It also elaborates how such a major transformation, from a bureaucratic top-down to a people's bottom-up system, can be undertaken as a People's Health Movement. The struggle for health will hence be closely related to the struggle for Panchayati Raj.

The technical and economic sustainability of this model is also described. Since this new approach to health and medical care will have to evolve over a period of time, the problems and procedures involved in the Interim Phase have also been discussed. This is not just another universal model to be imposed on the people by a top-down bureaucratic approach. It is essentially a people's own, bottom-up model. It can be utilised by a community of any size from a village to a taluka/block in rural or a mohalla in urban areas who desire a model for both health and medical care in keeping with their social-cultural, economic and local requirements.

This book is an attempt to demonstrate that so much can be done with so little.

□□□

2

Evolution of Health Care in India

Health has always been a major concern of people through the ages. In India this can be traced to the early civilizations of Harappa and Mohenjodaro which when excavated revealed well-planned cities with baths and drainage systems. Over the millennia several indigenous systems of medicine have evolved which have emphasised the maintenance of health rather than mere treatment of disease.

The Pre-British period

The Ayurvedic system was probably the first to be recognized as a systematized study of the science of health and healing using rational methods for diagnosing and treating illness. This has been recorded in the two great tomes 'Sushruta Samhita' and 'Charaka Samhita'. Ayurveda, like Yoga and the Siddha system, not only reflects an entire culture derived from the 'little traditions' of the people, but also highlights other aspects like mental and physical health and hygiene. It is as much a philosophical and spiritual as a physical approach to health and medical care. These well organized and well documented systems have their roots in folk medicines, herbal remedies and nature cure based on the belief that disease can often be prevented and even cured without the aid of medicines. Over time the medical aspects for the prevention and cure of diseases in India also incorporated foreign systems of medicine like Unani, Allopathy and Homeopathy.

The British period

The decline of the Ayurvedic system, chiefly utilized by the rulers and the elite, had already begun before the British came to India. Further deterioration of the system resulted with the introduction in the latter half of the 18th century of allopathic system of medicine introduced by the British rulers. This was introduced in India mainly to serve the requirements of British expatriates protect their military personnel, sepoys and associated local civilian elite especially from epidemics. With the establishment of several medical colleges in the 19th century, the allopathic system received a further boost in India. Largely based on the British model and needs it had little relevance to the needs of Indian society at large.

In 1835 Macaulay's Minutes put an end to the promotion of Indian systems of medicine which were deemed as being unscientific, and Sanskrit and ayurvedic texts were destroyed. By the end of the 19th century a number of Indian doctors had begun to practise the western system of medicine in the major cities, chiefly of a curative nature.

The Montague Chelmsford Reforms attempted to decentralize power and the provinces were given more say in the administration of health. However poor funding and bureaucratic mismanagement hampered the proper materialization of this plan. Poor health conditions continued till Independence despite various reforms which proved to be superficial, incidental and secondary.

The nationalist movement under Gandhi

tried to revive our indigenous systems of health and medical care and met with some success. It was the father of the nation who advocated a decentralized people-based form of rural development based on values and traditions which included the health practices of our civilization. He stressed that people in rural areas, should be at the helm of policy making that affected their welfare. He advocated health as a way of life and believed in naturopathy. The stress was on caring rather than curing, using non-formal methods of education, health and medical practices at the village level.

At independence

In 1930 the Indian National Congress set up the National Planning Commission. A sub-committee on health under the chairmanship of Col. S.S. Sokhey was formed to assess the health situation and the health services of the country. In 1943 the Health Survey and Planning Committee (popularly known as the Bhore Committee) was appointed by the British under the chairmanship of Sir Joseph Bhore, an Indian ICS officer. A comprehensive nation-wide survey carried out by the Bhore Committee revealed a high mortality rate among infants and mothers. The number of deaths caused by communicable diseases was also extremely high. Severe shortage of health personnel, hospitals and dispensaries, aggravated the problem.

The Committee pointed out that deaths could be prevented by better sanitary facilities, safe drinking water, proper diet and medical facilities. The survey indicated that malaria, cholera, small pox and plague were taking a high annual toll. These were the major concern of the British as these diseases could spread to their cantonments, even though diseases like tuberculosis and maternal and child death probably took a greater toll. The National Planning Committee on Health (1948) which was convened to plan the execution of the Bhore Committee's recommendations noted that poverty was the root cause of most diseases and the short life span of 27 years.

The Committee's strategy for establishing the health infrastructure was in two phases, the short and long term programmes, each with its own set of targets. The Primary Health Centre (PHC) was the basis of an integrated preventive-promotive-curative health care service for the 92% of the population which was rural. This included a proposed 75-bed hospital for each PHC for a population of 20,000. The emphasis was on preventive and curative work so that each could supplement the other, and on involving the people themselves. More specialized

Table 1
Health indicators on the eve of independence

Expectation of Life at birth	27 yrs.
General Death Rate	22.4 (per 1000 population)
Infant Mortality Rate	162 (per 1000 live births)
Death Rate of Children under 10 yrs	48%
Maternal Mortality Rate	20 (per 1000 live birth)
Disease-wise causes of deaths	
Fevers (including Malaria)	58.4% of all diseases
Respiratory Diseases	7.6%
Dysentery	4.2%
Cholera	2.4%
Small-Pox	1.1%
Plague	0.5%
Others	25.8%
Total	100.0%

* All figures are for British India in 1944 & do not include the Princely States.
Source : Government of India, Health Survey and Development Committee (Bhore Committee) New Delhi 1946.

services were to be provided by medical institutions distributed all over the country. It estimated a time frame of 30-40 years for achieving this Three Million Plan.

Shortcomings of the Bhore Committee Report

The shortcomings of this Report was that it was mainly based on the imported allopathic medical system. Despite the advent of allopathic medicine during the British Raj, the health practices and the indigenous systems continued to have the greatest influence on the life of the majority of our people. These systems were incorporated into the social and religious practices of the people. While not as dramatic as western curative medicine and surgery, they nevertheless played an important role in sustaining the mental and physical well being of the majority of our people. The Bhore Committee also failed to appreciate the entirely different socio-economic and cultural conditions and traditional health practices of the people. In actual practice the plan proposed by the Bhore Committee was not entirely decentralized and had a top-down approach. It also failed to appreciate the values and cultural difference between the urban trained health providers like doctors and nurses and the majority of our people. A major recommendation of the Bhore Committee was the use of a large number of paramedical workers based at the village level. It also recommended that the three-year licentiate medical course be abolished in order to standardise the quality of medical education and practice. Yet Drs. Vishwanath and Butt in a dissenting note stated that the "basic doctor as envisaged will not willingly fit into the rural scheme except under conditions of destitution". (GOI, 1946). This report also failed to utilize the indegenous systems of health and medical care.

Post independence period

The Bhore Committee report provided a ready made formal model which was available at Independence and was hence adopted as the blueprint for the country's post independence health policy. Unfortunately its specific recommendations were only selectively implemented and its deficiencies not addressed in view of later experience. In the 50s and 60s the major achievement was the control of the four major communicable diseases of pre-independence India, namely small pox, malaria, plague and cholera. Smallpox was eradicated, malaria which accounted for an estimated 100 million cases and 2 million deaths per year before independence was reduced to less than 100,000 cases and no deaths by 1965, plague and cholera were also contained to a great extent.

This was attained by mobilizing the vast human power and enthusiasm of the people of a newly independent country led by an equally small enthused band of public health professionals. This short-lived phase has since been neglected though similar results were achieved in countries of similar size and with similar problems like the former USSR and China. As a result the health-related programmes after this early phase lost their initial momentum. Despite their modest social and economic development other smaller countries like Sri Lanka and Costa Rica and even our own state of Kerala were able to offer their people effective health and medical care at remarkably low cost. This was documented by the Rockefeller Foundation in its report 'Good Health at Low Cost' in 1985. These and the later achievements of countries like China, Chile and Nicaragua demonstrate the predominant role of the political will in achieving health care for all citizens even while fighting a battle for the country's very survival.

The percentage of funds allocated in the Five Year Plans for health have been grossly inadequate and nowhere commensurate to the recommendations of the Bhore Committee. The allocation for the first two decades after Independence, though modest, saw the growth of health infrastructure and manpower to reach health to the 'tillers of the soil'. The later Plans, though much larger, (Table-2) focussed

more on the urban-based curative infrastructure like medical colleges, hospitals and the training of doctors even though the rural Primary Health Centres (PHC) suffered due to the unwillingness of such city-trained doctors to serve the rural areas and provide leadership to the rural health team of the PHC.

as tuberculosis, acute respiratory infection, resurgent malaria and water-borne diseases were ignored while those like cancer, heart diseases, stroke and arthritis which were more related to the urban rich continued to receive greater attention. The indigenous systems were relegated to an inferior role.

Table 2
Plan-wise public sector outlays on health

Rs. crores

Period	Total Plan Investments (All Dev.Heads)	Health	Family Welfare	Sub-Total	Water Supply & Sanitation
1st Plan (1951-56)	1960 (100%)	65.2 (3.3%)	0.1 ---	65.3 (3.3%)	11.0 (0.6)
2nd Plan (1956-61)	4672 (100%)	140.8 (3.0%)	5.0 (0.1%)	145.8 (3.1%)	74.0 (1.6%)
3rd Plan (1961-66)	8576.5 (100%)	225.9 (2.6%)	24.9 (0.3%)	250.8 (2.9%)	105.7 (1.2%)
Annual Plan (1966-69)	6625.4 (100%)	140.2 (2.1%)	70.4 (1.1%)	210.6 (3.2%)	102.7 (1.6)
4th Plan (1969-74)	15778.8 (100%)	335.5 (2.1%)	278.0 (1.8%)	613.5 (3.9%)	458.9 (2.9%)
5th Plan (1974-79)	39426.2 (100%)	760.8 (1.9%)	491.8 (1.2%)	1252.6 (3.2%)	1091.6 (2.8%)
6th Plan (1980-85)	109291.7 (100%)	2025.2 (1.8%)	1387.0 (1.3%)	3412.2 (3.1%)	3996.9 (3.6%)
7th Plan (1985-90)	218729.6 (100%)	3688.6 (1.7%)	3120.8 (1.4%)	6809.4 (3.1%)	7093.1 (3.2%)
Annual Plan(1990-91-92)	137033.5 (100%)	52253.8 (1.64%)	61805.5 (1.32%)	24059.38 (2.96%)	
8th Plan (1992-97)	434100.0 (100%)	7582.2 (1.75%)	6500.00 (1.5%)	14082.2 (3.25%)	

Sources :

1. Health Information of India - 1993, Pages 65-66 Central Bureau of Health Intelligence, Directorate General of Health Services Ministry of Health & Family Welfare, Govt. of India, Nirman Bhavan.
2. Ninth Five Year Plan Draft 1997-2002 Volume II, Page 200. Government of India, Planning Commission, New Delhi.

The heart of an over-centralised system, viz. the Ministry of Health and Family Welfare based in Delhi, developed plans which encouraged urban development of medical services though the majority of the population still remained rural. Diseases of poverty such

Another aspect of this period was the massive increase in manpower, infrastructure and financial inputs in the field of curative medicine. Though chiefly at the expense of the public sector it was indirectly supportive of the rapidly increasing private sector. This

invariably diverted attention from the more holistic approach of preventive and promotive aspects and people's participation as envisaged by the Bhore Committee especially for rural areas. This resulted in the PHC concept being relegated to a centralised health bureaucracy to help achieve the national targets of a variety of vertical programmes such as Family Planning, devised by international experts. As a result of target pressures and transfers and absence of curative care the PHC was further alienated from the community it was designed to serve. Its accountability was to its own bureaucracy and not to the people which it was to serve.

In the mid '70s, the Minimum Needs Programme was introduced. It produced Multi Purpose Workers (MPW) chiefly to achieve targets of Family Planning and control resurgent malaria under the garb of health care for the villages.

The Community Health Workers (CHW) scheme was inaugurated in 1977 in order to bridge the increasing distance between the government services and the community whose participation was essential to achieve the 'targets' of the various programmes. This too suffered at the hands of an indifferent bureaucracy which co-opted the CHWs, the community's own resource, into the lowest rung of the PHC. Curative medicine in urban areas continued to increase in a highly disproportionate manner, especially in the private sector, with some spillover of the excess to the rural areas.

One of the recommendations of the ICSSR/ICMR report of 1981 was to establish taluka level Rural Hospitals called Community Health Centres (CHC) to provide the curative services not provided by the PHC. This too was however imposed upon the people in a very ad hoc bureaucratic manner and therefore failed to serve the purpose for which it was devised.

Recognition of indigenous systems

The over-promotion and budgetary allocation for allopathic (western) medicine resulted in a severe setback to the indigenous systems. While the allopathic system does offer simple effective, cheap and safe knowledge and technology for the prevention, treatment and control of the communicable diseases, the greater contribution of the systems like Ayurveda and Yoga concerning the lifestyle diseases and the ageing process like cancer, heart, stroke and arthritis is only now being appreciated.

After independence the government had recognised the indigenous systems under the designation of ISM&H (Indian Systems of Medicine and Homeopathy). Unfortunately allocation of funds for the ISM&H less than 3 percent of the total health budget. This demonstrates the gross neglect of our own systems while awaiting the West to recognising them first. A sad reflection even after gaining Independence.

Unfortunately the cheapest and most effective means for control and treatment for communicable diseases offered by the allopathic western system has also failed to be implemented while attention is being ineveasingly diverted to the latest expensive curative medicine of the aged rich in an increasingly market-oriented healthcare model.

WHO Alma Ata Report

In 1978 India was a signatory to an international declaration which promised to provide basic health care for all. Unfortunately, this WHO Alma Ata Report called 'Health for All' did not make even a cursory mention of the Bhore Committee's report which was the original Health for All concept. Although China was not a signatory to the declaration, it implemented in letter and spirit the 'Health for All' concept following its Independence in 1949. In the absence of political will of the majority of the signatories, WHO quickly reverted to a Specific Primary Health Care which further eroded the integrated approach of the Bhore Committee. Had the WHO report been implemented with some modifications rather than with an entirely different emphasis,

it would still have yielded useful results.

ICSSR/ICMR Report - Health for All: An Alternative Strategy (1981)

A joint panel of the Indian Councils of Social Science Research and Medical Research was appointed in 1978 to study the problem of health in their widest perspective from both the medical and social, cultural, economic and political aspects and suggest the possibility of an alternative strategy. In its 1981 report the joint panel clearly stated that the major factors determining the health of the people lie beyond the realm of medical care and are admirably amenable to people's own effort. It emphasised factors like nutrition, education (especially of women), water, sanitation, housing and environment. Without minimizing the role of preventive and curative medicine it advocated an alternative strategy based on an overall integrated approach.

National health policy

The ICSSR/ICMR report analysed the success and failure of health and medical care in its widest socio-cultural, economic as well as the techno-managerial perspective. The government's own National Health Policy of 1983 also reiterated the Report's critique of the then existing health system in the following terms. "The proliferation of the present approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in urban or rural areas. Furthermore the continued emphasis on the curative approach has led to a neglect of preventive, promotive, public health and rehabilitative aspects of healthcare. The existing approach, instead of improving awareness and building up self reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. Over the years the planning process has largely become oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes." (GOI,1983)

Role of international agencies

There was a marked increase in funding from bilateral and multilateral agencies based on the advice of foreign experts during the 70s and 80s. Though relatively small as compared to the overall health budget it substantially influenced the direction of the health policy away from the Bhore and ICSSR/ICMR Committees and even from the WHO Alma Ata Declaration of Health for All to a variety of programmes for Specific Primary Health Care. Vast loans were sought and readily provided by the World Bank in the 80s. Even more extensive loans were sought and provided in the 90s to restore the 'cuts' in the public sector imposed by the International Monetary Fund under the Structural Adjustment Policy (SAP).

Poverty amongst plenty

The imposition of the SAP in the 90s led to further marginalisation of the 85% of the poor living in rural India. As a result tuberculosis, the most sensitive indicator of poverty, has shown a sharp reemergence as have malaria and water-borne and other communicable diseases. The response has not been the tackling of the basic cause i.e. poverty but securing further extensive international loans for programmes such as DOTS for tuberculosis and impregnated bednets for malaria and also for resurgent diseases like kala azar, filariasis, encephalitis, dengue, jaundice and other similar diseases, while the major attention was diverted to Family Planning and now to AIDS. Sixty Five percent of the overall funding from both bilateral and multilateral agencies is for Family Welfare, under euphemistic names like Family Welfare, MCH, EPI and RCH, also for building and equipping new Primary Health Care structures whose failure is the result of bureaucratic

corruptions and failure of leadership by the medical profession. The result is increased indebtedness, more loans, more pressure of SAP and increasing of the viscious cycle between poverty and ill health.

The public sector

At Independence it was the Bhore Committee's report that was adopted as the blue print for the development of the country's health policy. Despite its shortcoming, it attempted in good faith to provide an integrated model of preventive, promotive as well as curative care for outreach to the people.

Though constitutionally the responsibility of health lies with the state government, the health policies have instead been defined by the Central government, which also allocates grants from the Plan budget. Public services are organized differently in rural and urban areas, almost constituting two separate systems of health care.

Though 74% of our population is still rural 67% of the public sector budget is now provided to the urban sector. (Reddy & Selveraju 1994) This imbalance is reflected even more in the quality of the services provided to the rural people by a PHC which has failed not only in providing an integrated service but has even failed to provide adequate preventive and promotive care while neglecting curative services which are the felt-need of the people. The following are some of the major reasons for the failure

- The medical profession has failed to serve at the rural PHCs leave aside provide leadership to a large team of health workers. A disgruntled unmotivated leader who is more interested in illegal curative medical practice can hardly serve as the role model for the rest of the team. Most of the Medical Officers do not hold their subcentre clinics. In the absence of a supportive leadership and continuous education, the lower staff are required to carry out their responsibilities with whatever training they have been provided initially which in itselfis inappropriate for their actual requirements in the field. As a result health functionaries suffer from shortcoming in their knowledge and skills (II HMR, 1991).

- Hence the PHC is for all practical purposes directed and controlled by a general purpose constantly transferable health bureaucracy with the support of equally bureaucratized medical officers of the Center and States.

- They have converted the PHC into an institution for achieving the 'targets' for a variety of National Programmes for specific diseases and for Family Planning dictated by international agencies like the WHO, UNICEF, USAID and more recently the World Bank. Family planning continues to be the priority programme which has resulted in the majority of time being spent on identifying and 'motivating' eligible cases for Family Planning. (Ghosh B, 1991) As a result, time and energy to conduct other activities, including maintenance of extensive records is not available.

- The excessive target pressures combined with transfers and lack of elementary emergency and curative services has alienated the PHC from the community it serves. An ICMR survey found that the only sufficient stocks available at the PHC were those of vaccines, contraceptives and nutritive supplements. (ICMR 1991).Hence curative care is the weakest component in the rural health institutions inspite of a very high demand as demonstrated by the excessive health expenditure incurred by rural households on the private sector. A recent study brings to light that health care accounted for perhaps an average of about 20% of the gross income (Rao, 1997). The demand for curative care is met either by recourse to the district and city hospitals or chiefly by the private sector, while the infrastructure of the PHCs remains

grossly underutilized. Less than 8% of illness care of the population covered is met by PHCs (NCAER, 1991).

- Transportation facilities are not satisfactory and vehicles assigned to PHCs are made available only for meetings or for rounding up family planning cases (ICMR, 1991).

- Over 85% of all expenditure is on salaries leaving little for medicines, supplies, maintenance, repairs or transport. (Rao, 1997)

- The location of PHCs and Subcenters is more in conformity of the requirements of the staff and of the local political leaders than of the people.

- PHCs cover a larger population than the norm of 30,000 and their access was restricted to a radius of 6 kms. Furthermore, hardly any State has met the norm of one Community Health Centre per 80,000 to 1,20,000 population. (ICMR, 1991). Most are merely upgraded PHCs.

- Some of the major deficiencies of PHCs as evaluated by the ICMR in 1991 were lack of drugs and supplies and labour rooms and operation theatre facilities.

- The Westernized bureaucratic approach is not only lacking in understanding the health culture and practises of our people which sustains them, but also denigrates all indigenous systems practices and its practitioners. Its biomedical and techno-managerial approach to medicine also fails to appreciate the much larger social non-medical components of health.

- The greatest failure of the PHC is the lack of accountability to the people for whom they have little respect. Certain corrective measures that have been attempted to improve the existing system are the MPW scheme, the CHW scheme and the Community Health Centres (Rural Hospitals) have also failed due to this leaderless bureaucratic and target and transfer based approach.

- Extensive expenses on PHC buildings, staff-quarters, equipment and training with generous loans from International agencies refuse to address the root cause of previous failures. The vast unidimensional expansion of health infrastructure and health personnel is demonstrated in Table 3.

This 'more of the same' approach which has resulted in extensive increase in infrastructure and manpower has continued to

Table 3
Expansion of health services

(In numbers)

Health facilities	1951	1971	1992	1997
1. Medical Colleges	28	98	146	NA
2. Hospitals	2694	3862	13692	NA
3. Dispensaries	6515	12180	27403	NA
4. Community Health Centres	0	0	2186	2619
5. Primary Health Centres	725	5112	20701	22002
6. Sub-Centres	--	28489	131370	136324
7. Hospital beds(All types)	7178	348655	834650	NA
8. Doctor	61840	151129	410875	NA
9. Dentists	3290	5512	11300	NA
10. Nurses	16550	80620	385410	NA

NA - Not available

Source : Govt. of India, Ministry of Finance Economic Division, Economic Survey: 1997- 98 New Delhi March, 1998.

fail to deliver the goods because of the inability to define the underlying cause of the problems of this present system. This lies in the dehumanizing top-down bureaucratic approach to what is an intensely human activity which chiefly concern the individual, family and local community from which it has been alienated.

The Private Sector

There is virtually no worthwhile regulatory mechanism in the profit-oriented private sector which consists of practitioners of various systems and qualifications working in institutions ranging from private dispensaries and nursing homes to five star hospitals in the cities. In actual practice this sector is also dominated by the allopathic system. This sector now comprises three quarters of the entire health care system of our country, both in terms of numbers as well as the nation's overall health expenditure. The Private Sector accounts for 73% of allopathic and an even larger propotion of non-allopathic doctors, 56% of hospitals and 30% of hospital beds. (Jesani A, 1993)

The Bhore Committee reported that of the 47,400 doctors then practising in India, 34,400 (72%) were in the private sector. Of these 70% - 75% were practising in the urban areas.(GOI, 1946) Statistics reveal that from one doctor for every 6,700 population at Independence we now have one doctor for every 900 persons. This does not reveal their distribution in quality and quantity which is highly concentrated in the urban as opposed to rural areas and even within the urban situation in the more affluent urban enclaves. Around 13,000 allopathic doctors are added every year (Jesani A, 1993). The total number of doctors of all disciplines now exceeds one million.

The private sector extensively utilises the facilities of the public sector for training its medical, nursing and technical personnel besides getting various government subsidies.

The 1981 census shows that 59% of doctors practise in urban areas even though 75% of our population resides in rural areas. The trends in utilization pattern reflect the penetration of private doctors and institutions across India, now even in the more affluent rural areas. The high percentage of utilization of private doctors for minor ailments has been amply demonstrated (Rao,1997). Another glaring yet increasingly common practice of the sector is the unnecessary and at times even dangerous medical interventions in the form of drugs and injections, intravenous infusions and surgical operations. The objectivity of the private sector is vitiated to a certain extent by its close association with the pharmaceutical and medical instrumentation industry whose excessive promotional tactics have resulted in an exponential increase in the cost of medical care. This has resulted in an adversial relationship in the traditional doctor-patient interaction and enactment of the Consumer Protection Act. The private sector therefore needs far more regulation from the Medical Councils and governments to curb malpractices and to restore the traditional doctor-patient relationship of earlier years based in trust.

Table 4
Annual per capita household health expenditure

	MP 1991	Maharashtra 1987	Kerala 1987	NCAER (All India) 1993
Per capita Rs.	299	182	78	204
		Expressed in 1999 prices		
Per capita Rs.	550	489	210	319

Note : Prices of 1999 adjusted on the basis of CPI index given in the Statistical Outline of India 1998-99 - Tata Services Limited.

Sources : George A et al 1993; Duggal R & Amin S. 1989, Kannan K.P. et al 1991; NCAER 1993.

Voluntary health sector

The voluntary health sector also provides a small segment of health care services of our country. It consists of a heterogeneous group ranging from religious orders to socially-motivated individuals, groups and institutions. With the advent of Panchayati or People's Raj the voluntary sector has an important role to play in creating awareness and a spirit of self-confidence and self-help among the people. It can provide information, guidance, expertise and demonstration in the early stages of Panchayati Raj in order to help the community in developing self-confidence to take control of its own health to the extent feasible.

Increasing government and international funding has diverted this sector from being a watchdog and mouthpiece for the people to helping the government and international agencies to achieve their targets and goals in areas where they have lost credibility.

The corporate sector

In recent years the health care industry in India is witnessing rapid growth of corporatisation i.e. ownership of the health services by business houses. The medical profession as well as the drug and instrumentation industry that promote inappropriate high cost technologies have established a symbiotic relationship with the corporate sector based on profit rather than providing ethical services in keeping with the requirements of the vast majority of our people. Symbiotic relationship and support provided by the State to the corporate sector and their foreign collaborators has been a major step towards the demand for privatisation of curative medicine providing expensive medical care to a small segment of our population while neglecting to provide even basic care to the vast majority in a so-called democracy.

The pharmaceutical and instrumentation industry

In 1948, the drug production in the country was worth Rs.10 crore. (Phadke, 1998). It is presently worth over Rs.29,000 crore. (CMIE 1999). Though India now has the capacity to produce most of its drug requirements, the majority of our people are deprived of the right kind of medicines prescribed in the correct doses for the correct period of time. The Primary Health Centres (PHCs) suffer from acute shortage of drugs, whereas private drug stores often situated opposite public hospitals and PHCs are overstocked with expensive drugs which do not match the disease pattern of our people.

The production pattern of drugs is by and large irrational. WHO in its essential Drug List has recommended 258 drugs while the Indian pharmaceutical industry is permitted to produce over 60,000 drugs and formulations. Out of the WHO list only about 50 are required at the PHCs or in general practice. About 100 are to be prescribed by consultants while the rest are chiefly for hospital practice.

The Hathi Committee of 1975 recommended measures to reduce the irrationalities in the number and quantity of drugs to be produced and listed 117 essential drugs. It also stated that all new drugs should be registered under generic names. (GOI, 1975) None of these recommendations were implemented however under pressure of the pharmaceutical industry.

There are about 50,000 brand products consisting mainly of irrational combinations and yet the standard textbooks recommend only 30-fixed dose drug combinations (Phadke, 1996). In a recent study in Satara district of Maharashtra, it was found that due to irrational prescription, 69% and 55% of the money spent on prescription in the private and public sectors respectively is a waste (Phadke, 1995). The overall drug situation in India hence needs major redressal to ensure more rational medical care and control of wasteful expenditure. What is needed is a list of graded and affordable essential drugs required at each level of health care based on a WHO type of evaluation.

The Instrumentation industry for diagnostic and curative medical and surgical care is dominated by Western and Japanese technology and has received a boost due to its dramatic promotion by the private sector and the medical profession. The government has lent support by the reduction in the import duties under the guise of being 'life saving'. The import of medical instrumentation and appliances has gone up from Rs. 1,668 crore in 1990-91 to Rs. 9,570 crores in 1996-97. (Baru, 1998)

Panchayati Raj

Health has been converted into a lucrative business due to the nexus between powers operating within and outside the country while denying even elementary health and medical care to the vast majority who are poor. This policy has also diverted attention from health to inappropriate illness care. The influence of external assistance which amounts to only 1.6% of the total health expenditure of India plays no small role in distorting the values of those who have the power to control our country's destiny. Yet in this gloomy scenario also lie the seeds of change. Poor, illiterate but intelligent people now have the opportunity to wrest control over their own destiny through the power of the vote provided by Panchayati Raj.

Village communities or panchayats have existed in India since ancient times. The important characteristic of the panchayats (an assembly of five persons) was that they had been the centre of social life and an important economic and administrative force in the local village community more through wisdom and consensus than through a majority vote.

During the National Movement Gandhi defined his vision of village panchayats in the following terms: "My idea of village swaraj is that it is a complete republic independent of its neighbours for its own vital wants and yet interdependent for many others in which dependence is a necessity."

The first draft of India's Constitution did not stress the role of panchayats. The recent 73rd and 74th amendments to the Constitution are seen as a major step forward even though it is evident that any constitutional amendment cannot bring about meaningful devolution of power without a strong people's movement to ensure appropriate change in the political will to in turn change the existing system which has gone awry.

The provision for regular elections, reservation of one third seats for women, reservations for SCs, STs, administrative and financial powers in the panchayats and allocation of 29 subjects under Schedule II were all long-awaited measures to realise the dream of Gram Swaraj.

Panchayati Raj represents the struggle of the people to regain the power provided to them at Independence under universal adult franchise. Effective Panchayati Raj means that adequate resources, and power to administratively, and even more important financially control these resources. These powers must be transferred to the lowest level that is feasible.

Ralegan Siddhi and many similar models reveal the capability of the people to successfully implement at remarkably low cost almost all the activities necessary for their economic and social development once released from the stranglehold of the over-centralised existing system. The social background and the socio-economic and political factors play a major if not the key role in determining the people's health.

With Panchayati Raj constitutionally ordained and now operational in several parts of the country, this book which is an extension of the ICSSR-ICMR Report, hopes to provide a more detailed account of the people's model of health. This is based on the strengths of our own culture and utilises all modes and systems of appropriate health and medical care in an integrated and holistic manner. It also

takes into consideration the changes that have occurred in the intervening 19 years such as the availability of doctors and specialists at the taluka though not at the village PHC. Health has to be within the purview of the people, thus creating a whole new sector — the People's Sector which supercedes the Public as well as the Private Sectors.

Summary of the ICSSR/ICMR Report - 1981, Health for All : An Alternative Strategy

Since this book is an extension of the ICSSR/ICMR report based on its underlying concept and philosophy the reader is herewith provided salient extracts of the original report and its major recommendations. It is interesting to note that almost two decades later the conditions and recommendations still remain by and large still relevant. The few changes in the intervening 19 years both positive as well as negative are discussed and incorporated in this publication. This Report, under the chairmanship of Prof. V. Ramalingaswami and with the late J.P. Naik as the moving spirit, differed from all previous 'Health for All' reports as it viewed health as primarily an outcome of the overall integrated social and economic development of the entire society.

The Report commences by stating that "The objective of the national health policy should be to provide health for all by 2000 A.D. This implies the provision of a good and adequate health for all citizens, and especially for women and children and the poor and underprivileged groups. It also implies a drastic reduction in the overall morbidity and mortality. These objectives and targets are realistic and feasible but they cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. Nothing short of a radical change is called for."

"Health is a function not only of medical care but of the overall integrated development of society - cultural, economic, educational, social and political. Health also depends on a number of supportive services - nutrition, improvement in environment and health education".

"The objectives of integrated development are to eliminate poverty and inequality, to spread education, and to enable the poor and underprivileged groups to assert themselves. This requires:

- Rapid economic growth with egalitarian distribution of wealth.
- Full-scale employment, including a guarantee of work on reasonable wages to every adult who offers to work for eight hours a day; creation of adequate opportunities of gainful employment for women.
- Improvement in the status of women with a determination to check the adverse sex-ratio and to make it rise substantially upwards.
- Adult education with emphasis on health education and vocational skills.
- Universal elementary education for all children (age-group 6-14 to be provided by 1991.
- Welfare of Scheduled Castes and Scheduled Tribes.
- Creation of a, democratic decentralised and participatory form of Government.
- Improvement in housing with emphasis on the provision of houses for the landless and slum clearance.
- Organizing the poor and underprivileged groups."

"There should be a National Population Commission set up by an Act of Parliament to formulate and implement an overall population policy. The Family Planning programme must be converted into a people's movement closely linked to development. The

emphasis should be on education and motivation, especially through interpersonal communication and group action".

"Nutrition will have to be improved through adequate production of food, reduction in post-harvest losses, proper organization of storage and distribution and increasing the purchasing power of the poor through generation of employment and organisation of food-for-work programmes. Emphasis should be placed on improving the nutritional status of women and children...."

"Improvement of the environment will reduce infection, make programmes of nutrition more effective, and help materially in reducing morbidity and mortality. Safe drinking water supply will have to be provided to all urban and rural areas. Good sewage dispersal systems should also be established."

"Health education should become an integral part of all general education and should receive adequate emphasis...."

Alternative model of health care services

"Within the health sector, our most important recommendation is that the existing.... centralised and bureaucratic large urban hospitals.... be replaced by the alternative model of health care.... This alternative model is strongly rooted in the community, provides adequate, efficient and equitable referral services, integrates promotive, preventive and curative aspects, and combines the valuable elements in our culture and tradition with the best elements of the Western system. It is also more economic and cost-effective".

"Communicable diseases still form the largest cause of morbidity and mortality and the fight against them should be continued with still greater vigour in the years ahead. A good surveillance system has to be set up and better coordinated efforts are needed..."

"Under the new alternative model, the organisation of the health services will be radically different from that in the existing system. A new category of personnel, the Community Health Volunteers will be introduced and will be the main bridge between the community and the services. Important decisions will have to be taken about nurses, paramedical, doctors, specialists and super specialists and these relate to their numbers, quality and duration of training, and value system. There should be adequate arrangements for the continuous in-services education of all categories of health personnel...."

"There is need for a clear-cut drug policy and a National Drug Agency to implement it. The pattern of drug production should be oriented to the disease pattern, with an emphasis on the production of basic and essential drugs which should be produced in adequate quantities and sold at cheapest possible prices".

"The priority areas for research obviously are primary health care, epidemiology, communicable diseases with a special emphasis on diarrhoea, environmental research, and research on drugs, problems of rural water supply and sanitation, indigenous medicine, health implications of industrial development, and family planning...."

"....The existing priorities should be radically altered and the bulk of the additional resources will have to go into promotive and preventive activities in rural areas and in the development of supportive services like nutrition, sanitation, water supply and education, and for providing health care services to women and children and the poor and underprivileged groups".

"The programme will depend upon our capacity to create a mass movement to work for it..... It will be proportional to the extent to which it is possible (i) to reduce poverty and inequality and to spread education (ii) to organise the poor and underprivileged groups so that they are able to assert themselves, and

(iii) to move away from the Western model of health care and to replace it by the alternative model based in the community...."

The approach
An alternative national health policy

"The proposals for reform fall into two broad categories. One approach assumes that the existing programmes are, on the whole, moving in the right direction and that what we need is marginal adjustments and changes such as more research, more hospitals and dispensaries, more and better trained personnel, more drugs and, above all, more funds. We believe that several of the assumptions on which the present system is based are wrong. For instance, there is no distinction between planning for `health' and that for `health services' so that little or no attention has been paid to the social, economic, political and cultural dimensions of health. Health is regarded as a responsibility of the Ministry and Departments of Health whereas it ought to be a national responsibility of all concerned -the people and the State... The serious shortcomings of the model cannot be cured by small tinkering or well-meant reforms. The health of a society is intimately related to its value system, its philosophical and cultural traditions, and its social, economic and political organization..."

Health and economic development

"One of the best established epidemiological findings is that the prevalence and distribution of diseases is strongly influenced by economic factors. A cross-tabulation of prevalence or incidence of diseases by economic class in a population group shows that most infections and nutritional deficiency diseases common in developing countries can really be considered as "diseases of poverty'. As living conditions improve, they have tended to disappear spontaneously...."

"There is hardly any basis for the `downward filtration' theory viz. that improvement in education and health will gradually but automatically trickle down from the upper and middle classes to the poor people..."

"The synergism between poverty, malnutrition, infection and increased morbidity and mortality is now well-established. In other words, `poverty' itself is an extremely tenacious disease...."

"Given favourable social and political factors, even a comparatively limited economic growth can lead to an outstanding improvement in health status. This was clearly demonstrated in China and Cuba. It is also seen in Kerala where the improvement in health status is far better than that in the more affluent Punjab because of a wider spread of education. greater social equality and deeper political awakening...."

Health and social development

"As social and educational development takes place, there is a general trend for a simultaneous improvement in the health status as well..... It raises the age of marriage and it increases an individual's capacity to take advantage of the health services which the government has provided. The converse is true in this case also. An improvement in the health status of a child increases his attendance at school and improves his performance. Similarly, improved health status is also found to contribute to upward mobility and ultimately to reduction of social inequalities."

"The intimate connection between political development and health status is well-established. In most developing countries. oligarchies of the upper and middle classes are in power. Their health status is very good and they derive the largest benefit from the public health services. On the other hand, the poor in these countries who form the large majority and are deprived of effective political power, have a low health status and receive only marginal benefits from the public health

services. The situation is very different in countries where the democratic process is taken to the community level and the common people are involved actively in planning and implementing programmes for their welfare. Here the health status of the people as a whole has improved and the inequalities in health status of different social groups tend to be reduced....."

Health and integrated development

"Since economic, social, educational and political developments are complementary, it follows that the best results can be obtained from integrated development which means that the contribution of all sectors to health has to be recognised and collaboration encouraged."

Health and family planning

"The provision of modern health services reduces death rates very rapidly but the adoption of the small family norm as a way of life is a long drawn out process which societies are slow to internalize.... The best way out is to push ahead, because it is only a programme of further improvement in social, economic and political fields combined with a still further improvement in health status that can help to reduce the birth rates substantially and on a permanent footing."

Democratic decentralization

"It is necessary to emphasise the need for democratic decentralization if a good alternative health care system is to be evolved.... Health is now regarded, not as a commodity or service, but as a process of living and being, a close involvement which will make individuals and communities healthy.... The present view is that the goal of health for all can only be reached through a fully democratic process.... It is necessary to abandon the existing centralised and top down approach to the organisation of health services and create a new system of building from below with community-based health services. This will be possible in a democratic, decentralised, and participatory system of government in which the people in a community have the authority, resources and expertise to prepare and implement all plans for their welfare. including health."

Basic principles and approaches of the alternative model

"The new system of health care services should be strongly based in the community so that the people could be intensively involved in planning and implementing programmes for their own health care. By a community, we means a population of about 100,000 which will have a Community Health Centre, with a sub-centre for every 5,000 population and a village or neighbourhood service centre for every 1,000 population. Most of the health problems of this community should be taken care of by the community itself and more than half the expenditure on health services should be incurred within this community. It is from this firm and solid base that the health services should rise to the top, providing supplementary, referral, specialized, and super-specialised services at the district, regional, State and national levels."

Community health centre hospital

"The large, urban hospitals in the existing system should be eliminated by establishing a small, community hospital of about 30 beds in every community of 100,000 people....

The advantages of such a small community hospital which is a part of the Community Health Centre will be physical proximity to the people; greater cultural acceptability; personal attention as a result of small size; facility for relations who can accompany and stay in the adjoining dharmshala and feed the patients and take part in the nursing care, thus leading to a humane approach; avoidance of the inhuman, impersonal approach of the large hospital and

Part II

The Community Health Care System

3

Community Health Care System : An Overview

Part I has described the evolution of health services from its origins in the folk and indigenous systems and analysed the more formalized Western medicalised model that dominates the present health scene. It has also summarised the ICSSR/ICMR alternative model.

In this model the non-medical components which provide the very foundation for health can be most effectively undertaken by the people themselves as a part of their overall social, cultural and economic and political activities. Contrary to common belief the majority of the preventive, promotive and curative aspects of medicine also lend themselves admirably to the people's own effort. This can be achieved by imparting knowledge and skills and providing facilities to local women in both health as well as medical care. This should be undertaken in a graded manner from the village to that at the taluka/block level with its People's Hospital and Health Complex. Such a people-based, people-involved, people-controlled and people-managed system can solve upto 95% of all health and medical problems of the community within the 100,000 population level. This is entirely different from the functioning of the existing public as well as private health systems. The ICSSR/ICMR report had defined the difference between such a decentralized peoples own health model as opposed to the centrally operated bureaucratic techno-managerial public sector and an over-medicalized and excessively profit-oriented private one to both of which we have drifted. Now that Panchayati Raj has received constitutional approval it provides the necessary basis for implementation of this report. Part II not only outlines the model suggested but also provides more detailed information for implementing what is essentially a **People's Health Sector** in preference to the existing Public or Private Health Sectors.

This model conforms broadly to the existing rural Primary Health Care structure eg. Community Health Worker at the village level, the subcenter at the 5000 level and the Community Health Center (Rural Hospital) at the Block/Taluka level. The Primary Health Center (PHC) is omitted because as described in Part I it serves neither the preventive, promotive nor the curative functions for which it was originally conceived. Even the ICSSR/ICMR Report in 1981, had eliminated the PHC in its alternative strategy for Health Care. The People's model strengthens both these functions at various levels based on the social requirements as well as providing appropriate technical knowledge and skills, and facilities necessary at each level. Improved transportation and communication is provided to support and coordinate the functioning at all levels and maintain a closely knit integrated service from the village to the taluka/block level.

And yet this health care system though broadly conforming to the existing Public Rural Sector is different in both in its concept and functioning. The aim of this publication is

to provide a more detailed guide to the Panchayats at the village, group Gram Panchayat and the Panchayat Samiti Taluka\Block level for developing a People's own Health and Medical services in an integrated manner according to the specific requirements at each level while ensuring an integrated system functioning as a whole. **Since the conditions and requirements vary from village to village and taluka to taluka this cannot be another universal countrywide model which can be imposed by the Center or State or even by the District authorities for this would be the very negation of the People's Health Model.** This is not another hypothetical concept devised in Geneva or Delhi but is based on the extensive field experience of a large number of smaller scale experiences in our own country as also on the large scale experience of countries like China.

This is an **indicative** model for any Panchayat at any level which desires to undertake a comprehensive health care system of its own. It is understood that such a model can be undertaken on a large scale as a whole when Panchayati Raj is operational on such a scale. **Yet it should be emphasised that any component of this model i.e. at the village or group of villages can be effectively utilized even without the availability of a People's Hospital and Health Centre** as in the comprehensive model since the functionaries will be trained to utilize the available public and private services in a more appropriate and useful manner. The Community Health Care System or any of its parts should be undertaken only when there is a community desire to implement such a health care model. This can be undertaken by individual villages, group of villages, NGOs, corporate houses and even by a district or state desirous of providing good health and medical care to all concerned.

The authors realise that such sweeping changes cannot be brought about overnight. Globalization and indiscriminate privatization in the present market-driven world has further polarised societies and marginalized the poor. It propagates and lends support to an entirely opposite mode of development which benefits a small affluent minority at the cost of basic care to the majority. The effect of such marginalization is seen even in the affluent Western societies like the US where 45 million (15% of its population) are denied basic health care despite spending over one trillion dollars equivalent to $3644 per capita per annum (UNDP, Human Development Report 1998). This is in stark contrast with the per capita $15 of Kerala whose health status as represented by its IMR of 15 (CSO, Dept. of statistics, Govt. of India, selected socio-economic indicators, 1995) is not far behind that of the US IMR of 8 (WHO, The World Health Report, 1996). Under market pressures our medical profession has by and large also succumbed to the Western profit motivated privatized model and hence cannot provide the necessary leadership to ensure Health for All. Together with the burgeoning health industry this has led to diverting over 20% of the meagre resources of our poor, 36% of whom are still below the poverty line, from nutrition and health to inappropriate illness care.

Hence the decision for achieving Health for All through a people-based approach lies primarily in the realm of politics and peoples own demand and action rather than more medical science and technology as demanded by the medical profession and the health industry. Panchayati Raj provides the opportunity to the people to implement a health service which admirably serves their needs well within the country's available resources. This publication demonstrates both its technical, social and financial feasibility.

The time for tinkering with the existing over-centralized, over-bureaucratised and over-medicalised political and medical system is well past. With remarkable foresight, Gandhiji with Gram Swaraj as his vision for India's post-Independence development, also

ensured universal adult franchise to empower the people to achieve this. Fifty years later the people deluded by repeated false promises are now able to look beyond the present form of development which has bypassed them, and have achieved Panchayati Raj which has been conceded under the pressure of their vote through the 73rd and 74th Constitutional Amendments. Under Section 11 of the Schedule, 29 subjects covering almost all aspects of rural development have also been conceded to them, of which health is one. This also demonstrates their growing awareness of their political and social rights as expressed through their vote.

The transfer of power and resources will naturally be opposed by those who hold the reins of power and those who benefit under the existing order. An awakened people will have to fight for what is their rightful due. In the over-mystified field of 'health' the transfer of power and resources will be more difficult than in a field like agriculture or even veterinary medicine. As such it will need intensive promotion, especially by actual demonstration in the field as was done in the early stages of the green revolution.

The following chapters of this book provide information regards the conceptual, social, technical and financial aspects for implementation of this People's model for improving their health and medical care. It also provides the philosophical considerations underlying the process of decentralization where local people at every level have to assume responsibility for their own welfare and overcome the age-old dependency on external agencies whether public or private. It also explains the predominant role played by non-medical factors like nutrition, education, water, sanitation and environment in determining health and demonstrates how these are almost entirely within the purview of the people themselves.

It also aims to demonstrate that contrary to prevailing engendered belief, even in the field of illness care, the most important promotive and preventive aspects are also chiefly within the purview of the community itself. It illustrates how, even in the mystified field of medical care, the majority of the functions also lend themselves admirably to the community's own effort with the help of specifically trained workers at the village and Group Gram Panchayat 5000 population level. It explains the approach to the training of functionaries for these requirements at each level including the training as well as the type and mode of support which is to be continuously provided by the specialised professional services at the People's Health Hospital and Training component of this integrated Community Health Care System. Except for a few professional staff all the rest have to be recruited and trained within the taluka itself at each level, both initially as well as by a continuous education process. This will ensure relevance of training to the local reality besides continuous interaction between teacher and student at every level which is so lacking in the present system.

Most of these functions, non-medical as well as medical, can be best undertaken by local women if suitably trained and assured of appropriate and continuous support. This can also provide large scale useful and remunerative employment to women within their village or taluka township at prevailing rates and serve what is also a crying national need. This can also be a powerful means for womens empowerment.

Chapter 14 also demonstrates how there exists ample availability of both human as well as financial resources at a relatively low cost for providing such an efficient service to all citizens. The Panchayats at every level will have to take financial as well as administrative responsibility and control for what will now be their own service for serving their own needs free of the exploitative profit motive. The few external personnel like doctors and nurses can be employed by them at the prevailing market rate. Adequate remuneration

and good medical facilities will have both job satisfaction as well as accountability of these professionals to the people. They will eventually be integrated into the community they serve. The large scale demand for this type of manpower will also help to correct the mismatch of numbers and training of medical, nursing and paramedical humanpower in the existing system through pressure of demand and supply.

Such a system based within the Panchayat Samiti/Block leaves very few functions for the District, State and Central levels and that too in a decreasing and graded manner. The redressal of the urban-rural imbalance in the public sector expenditure together with the savings on the unnecessarily expensive private sector can provide more than adequate capital as well as recurring financial resources to operate such a People's own system.

Modification of such a decentralised health and medical system can also serve the needs of most of the urban population.

Since this will take a decade or two to become fully operational a chapter is devoted for the intervening Intermediate phase.

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4

Organisation Structure

Community Health Care System (CHCS)

	Population (approx.)	Functionary	Responsibility to	Approximate proportion of the total services covered
1.	200	CHF	Neighbourhood Group	70%
2.	1,000	VHF	Gram Panchayat	
3.	5,000	Sahyogini	Group Gram Panchayat	85%
4.	1,00,000	People's Hospital People's Health Centre	Panchayat Samiti	95%

5

At the Village Level

The community health functionary

A major cause of the failure of the Primary Health Centre (PHC) has been the inability to gain the cooperation of the people from whom it has been alienated due to the inability to provide curative services which is their felt-need. This, together with lack of professional leadership, constant transfers, and the tyranny of 'targets' such as of Family Planning, has alienated the PHC from the community it serves.

The superior results of the decentralized village 'barefoot' doctor approach of China has also been confirmed by several of our own voluntary organizations utilizing a community-based approach. Based on these experiences our government also introduced the Community-based Health Workers (CHW) Scheme in 1978. Unfortunately the very essence of this community-based participatory approach failed to be captured by the health bureaucracy or by the PHC. The CHW, provided a meagre honorarium of Rs.50 per month, was promptly coopted into the lowest rung of the bureaucratic system as a new means for gaining 'community participation' for achieving government's 'targets'. It is hence not surprising that this laudable approach ended up as a caricature of the original concept. More than one lakh CHWs, (94% male) were selected and appointed within a period of 10 days. This reveals how even a well demonstrated scheme fails when implemented only to serve the requirements of an indifferent and insensitive bureaucracy. This has resulted in an unnecessary setback to the development of a key component for involvement of the people in their own health care.

Biologically it is the woman who has the caring and nurturing instincts, the key requirement for Community Health. A new type of female village health functionary is hence required to cater to the needs of the 70% of the population which consists of women and children. This segment of the population also suffers from the majority of health and medical problems of the community.

As described previously health involves a gamut of activities at the village level and is essentially a social problem with technology playing a supporting role. This has failed to be appreciated by the techno-managerial approach of the existing system. There is ample experience which demonstrates that over 70% of the common health problems can be tackled effectively by the community within the village itself with the help of their own health functionaries, if provided with specific training and utilizing knowledge and technology available from all sources. With their inherent social skills, ready accessibility and natural accountability to their own community they can be trained effectively to perform most of the health and even the majority of the medical functions of their community. This can provide both health and medical care in a humane manner at remarkably low cost as recommended in the ICSSR/ICMR Report in 1981. Referred to here as the new Community

Health Care Functionary (CHF), she provides the foundation to this community-based model for both health as well as medical care.

The chief asset of the CHF is her natural affinity and concern for her own community of which she is a member. It is this quality which differentiates her from all existing health functionaries. It permits her to achieve with relative ease, not only the social functions of health but also many simple but nevertheless important technical medical functions which more highly trained professionals are unable to 'deliver' from a distance. This is because the majority of health and illness problems of the community require relatively simple knowledge and technology for their solution but a very high degree of motivation and social skills so essential to achieve the desired results. Being a part of the community she is also aware of the local culture and practices as well as their "little" traditions of health and medicine, which would be difficult for any external professional to understand.

At present the training of ANMs and Multipurpose Workers at District Training Centers is more for the convenience of the urban-located professionals and bureaucracy. It has little relevance to the problems or tasks to be performed at the village level. Their aim is to achieve the 'targets' of the PHC set by a distant bureaucracy. The social, economic and cultural factors that ultimately determine the effectiveness of such functionaries, even in achieving these targets, has no role in such training. The training of the CHF hence has to be provided to the local village woman within the community by the functionary at the next level who supports her namely the Village Health Functionary and Sahyogini and who will eventually function with her as a team. Following an initial intensive period at the taluka Training Center such training has to be at the local level and of a continuous nature integrating theory and practice with her ongoing work.

The selection of the CHF in the Communiy Health Care System must hence rest entirely with the local Neighbourhood community which she will eventually serve. It cannot be decided by the Panchayat Samiti or the health or medical staff at the Block/ Taluka level and certainly not by the District or State authorities. Transfers and targets which are the impositions of a hierarchical 'delivery' system are anathema to such a people's model. The single-most important criterion for selection is social motivation to serve her own community, which for her is an extension of her family, and her acceptance by them. Every locality within a village can identify one or more such individuals. Preference should be given to a woman who is married and permanently settled in the village, whose children are fairly independent of her, and whose family is willing to support her in her new role. Basic reading and writing skills available to a 5th standard educated person are adequate. Higher education per se should not be the criterion for selection. Even motivated illiterate tribal women, helped by their children to keep the records, have fulfilled many tasks of the CHF in a more satisfactory manner than a more educated functionary from outside or even from within her own community who lacks innate motivation and the trust of the people and rapport with them.

The emoluments of such a functionary, whether full-time or part-time, must be left to her own community who will generally decide on the basis of what a woman undertaking similar work and giving of her time would be normally entitled to. This will hence vary from community to community and village to village. It will certainly not compare with the excessive remuneration provided by the public sector to their unionised staff. Accountability will be assured not only as a social function, which is visible to all, but also because the remuneration and the power to terminate services rest with her community.

The choice of appointing a full-time, part-time, or even several part-time workers to serve a limited population is also the privilege of the local community depending on their requirement. The prestige that such

workers enjoy in their own community is their greatest reward though it is the natural obligation of the community to remunerate such functionaries adequately for the time given and services rendered. There is no reason to consider them as mere volunteers paid a meagre honorarium of Rs.50 as is at present by the government to their Health Guides.

The CHF on an average can serve a population of about 200 effectively covering 50 houses. This coverage would vary depending on the population and its distribution. This ensures close social interaction as well as monitoring of her functions by her own community who would in turn support her in her work. Such a part-time functionary covering a small neighbourhood can also undertake several other functions like non-formal education, operating a library or balwadi, and even veterinary care or a small savings scheme if she is given the necessary training and support. This would further enhance her standing in her community, provide increased job satisfaction and possibly additional monetary benefit. Such activities can also help her in her health-related functions. A major advantage of the CHF serving such a small neighbourhood rather than an entire village like the CHW is that it avoids domination by any single caste. It also ensures personal rapport and service to interest in those who are a part of her extended family. No house to house visits and extensive records are necessary, as in the case of the ANM to carry out her multiple tasks. Besides, she and her family are also affected if the health of her community suffers. This is very different from the functioning of workers in the existing system where a single worker subject to transfer and target pressures has to cover 5000 population.

Confidence of the community in their CHF and her own self-confidence will depend, at least in the early stages, on her ability to render a few simple but important and useful curative services. The fear of the professionals that this will encourage quackery can be prevented by informing the community of the extent of her training and functions she can undertake with safety. It is interesting that only a few voices are raised against malpractice by members of their own profession. The denial of services to the people which the professionals themselves have failed to provide in an ethical manner for half a century after Independence certainly cannot justify such criticism. An informed community is better able to prevent malpractice by such village workers and even by professionals.

The WHO has permitted the use of several drugs even by lay persons and these are available over the counter. More can be permitted in a graded manner, with increased training. Even drugs for major diseases like tuberculosis and leprosy can be provided to patients by such village functionaries under the direction of professionals after confirmation of diagnosis and prescription of the regimen. This is a far more effective and cheaper way to ensure regular treatment for diseases like leprosy and tuberculosis than through expensive individual programmes such as Direct Observed Treatment (DOT) delivered by disease specific external or even local functionaries, as stigma of the disease is soon attached to them. It is possible that with adequate training and experience, programmes such as immunization can also be more effectively implemented with safety at a far lower cost by such village functionaries, under the guidance and supervision of the Sahyogini and the Public Health component of this system. The advantages of the CHF in Family Welfare and other national disease control programmes are discussed in the relevant section. The use of home, folk and local herbal remedies, if only as placebo, should be promoted as also the use of other systems of health and medical care.

Since the majority of health problems are non-medical, like nutrition, water, sanitation, education,housing and environment, the CHF can play an even more important role in creating awareness for involving her

community in such tasks as the benefits will accrue not only to them but also to her own family. This consists of functions like the maintenance of hand pumps and wells, safe storage of drinking water within the home, water management, sanitation, cheap toilets and soakage pits. She can also encourage and demonstrate better use of available nutrition, non-formal education, health care of school children and prevention of unnecessary use of chemical fertilizers and pesticides. There is no better means for ensuring Health Education for the community than through their own local health functionary, often in an ongoing informal manner. An important function would be the creation of awareness of health in her own neighbourhood in the same informal manner through her own example.

The CHF will also help her community to make effective use of the graded referral services of the entire Community Health Care system which are now available from the VHF and SRU to the People's Hospital and Health Centre. She can also help the community for better utilization of the private sector, the financial savings of which would help to support her and also provide a cheaper and more efficient people's own health service.

The functioning of the CHF, even though of a semi-formal nature, must be transparent. The entire community that she serves must be kept informed about her activities and they have the right to demand any relevant information. Her duties, job specifications and work reports must be displayed in a prominent place. This will also encourage participation of the people. Transparency is especially important in the collection of fees for drugs and services. Receipts must be provided for every transaction. All collections must be transferred each month to the account of the Village Health Committee of which the CHFs are also members. This eliminates the danger of malpractice and corruption. It is up to the community and its Health Committee to decide the remuneration of their workers and ensure the purchase and utilization of drugs and supplies in a prompt and appropriate manner.

The functions of the CHF are broadly as follows

- To attend to all preventive, promotive and curative medical as well as the non-medical health problems in consonance with her knowledge, skills and facilities.

- To provide health information and education and encourage people's participation and support.

- To maintain basic records.

- To refer difficult problems to the VHF and / or Sahyogini.

- To facilitate early detection of tuberculosis, ARI, diarrhoea and similar conditions and ensure regularity of prescribed treatment after confirmation of diagnosis eg. for tuberculosis and leprosy.

- To provide pre and post natal care.

- To help those requiring Family Planning advice and help.

- To liaise with the VHF and village health committee.

- To undergo continuous education through her VHF and sahyoginis.

- To provide first aid prior to and transfer of emergencies.

The CHF thus provides a sound base for the pyramid of the entire Community Health Care system with her unique social advantages and simple but effective medical knowledge and skills. She is easily accessible and available at all hours of the day and night. She represents and is accountable to her community and not to a distant hierarchical bureaucracy. She commands the back up of an entire health and medical care system which also belongs to the community.

The village health functionary

Like the CHF, the Village Health Functionary's (VHF) chief asset is her natural affinity and concern for her own community of which she and her family are a part. As a full-time worker giving eight hours per day for six days of the week, 50% of her time will be that of as a CHF for her neighbourhood 200 population while the other half will permit her to train and support the other CHFs of the village with her additional training and her interaction with the sahyoginis at the SRU. She will also help in consolidating the health statistics and records of her village, informing and organising the village community for support of health activities and ensure medicine and supplies to all the CHFs health workers of the village.

Other Functions of the VHF includes

- Care of epidemics and emergencies.
- Treat, hold or refer cases to the SRU.
- Conduct uncomplicated multipara deliveries within the village and treat certain common emergencies.
- To maintain liaison with the sahyogini and participate in the process of 'reverse referral'.
- Coordinate the preventive and promotive functions.
- Conduct training of the CHFs, both initial and continuous.
- Ensure immunizations and other national programmes.

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6

The 5000 Population Level

The Satellite Referral Unit (SRU) and the Sahyogini

The Primary Health Center (PHC) as conceived by the Bhore Committee was designed to provide an integrated curative, promotive and preventive service to a population of 20,000 in the rural areas.

Unfortunately the best of plans often go astray. The dependence of the Bhore Committee on the medical and nursing profession for providing the curative services at the PHC as well as leadership and support to a large team of paramedics for outreach of services to the villages has failed to materialize. Three quarters of our population who continue to live in 700,000 villages receive no meaningful form of health or medical care even 50 years after Independence being the citizens of a so-called democracy.

These five decades have also demonstrated that the majority of health as well as medical problems have a higher societal than technical component. Hence the community with the help of its own specifically trained health functionaries can effectively tackle most problems. This does not negate or reduce the role of the professionals but indicates that the roles of all functionaries need to be more clearly defined, based on both technical as well as social, cultural and economic considerations including the changing political milieu.

The ICSSR/ICMR Committee in 1981 had indicated the roles of the community, the paramedicals and of professionals in a decentralized model. It stated that in such a model over 95% of all health and medical problems could be solved within the taluka/ block level 80% of which could be at the village level. Even the Bhore committee stated that "in a statistical study spread over six years in Bhopal state, it was found that 83% of the total ailments were amenable to simple treatment, if given in time, that 13% need hospital care and that only 4% required specialised treatment." (GOI, 1946). In the intervening years not only has Panchayati Raj been constitutionally ordained but the community has also demonstrated its ability to undertake the majority of the 29 functions devolved to them including health.

As a result of the failure of the PHC as described in Chapter 2 the gap between the knowledge, skills and facilities available at the village and at the taluka levels need to be bridged by a new type of intermediary setup different from the PHC. This can be best achieved by a small but effective unit at the 5000 population level termed as Satellite Referral Unit (SRU) which based within the village also has a strong social and cultural component. The functionaries called Sahyoginis should in addition have sufficient medical knowledge, skills and facilities to bridge the gap between the requirements of village and that available at the taluka level. The 100,000 population covered by the taluka/ block should have 20 such Satellite Referral Units (SRUs) each serviced jointly by four

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Sahyoginis who are local women trained for two years for the speicfic requirements at this level. Provided adequate facilities they can handle the majority of the problems that do not require the services of qualified doctors and nurses. An important function of the Sahyoginis consists in providing continuous education and support to the CHFs and VHFs of the villages covered by the SRU. In turn they will be provided regular weekly support by a team of medical and health professionals from the taluka center who will visit the SRU every week to provide a Reverse Referral service which will also provide adequate professional service to the villagers near their home for non-emergency problems.

This together with good communication and transport facilities at its command will inspire confidence in the SRU even for emergency problems. Unlike the urban trained doctor and nurse, the Sahyoginis being local women will have both the social affinity as well as technical skills to serve their community, without the pressures of 'transfers' and 'targets' They will be available all hours of the day and night and be accountable to the community which selects, appoints and remunerates them. Their salaries will also be far lower than that of the present government ANMs and MPWs, being at par with other similar workers in other fields in the villages. They will also enjoy far greater job satisfaction and respect of their own community which money by itself cannot ensure.

The SRU with its Sahyoginis will serve a crucial intermediary function in the Community Health Care System. Four Sahyoginis will be ideally required at each SRU to ensure adequate round the clock service at the SRU level. This will also enable the Sahyoginis to receive both initial as well as continuous training at the taluka level to update their knowledge and skills and also enable one of them to visit the villages and wadis covered by the SRU at least once a week. The provision of four Sahyoginis also makes allowance for leave, absence or training of a new recruit to ensure uninterrupted services.

The following are some of the major functions of the Sahyoginis:

- Attend to all preventive, promotive and curative problems of the 5000 population.
- Train and support the 5 VHFs and 20 CHFs in the area covered by the SRU.
- Undertake emergency care, provide first aid, and consult and utilize the taluka health and medical facilities utilizing the communications and transport at their command.
- Maintain records and statistics for local utilization and forwarding to the taluka level.
- Be accountable both socially, technically and financially to their Group Gram Panchayat and its health committee.
- Mobilize community support for health and medical functions.
- Ensure effective implementation of all national programmes including Family Planning.
- Undertake uncomplicated deliveries of all primipara at the SRU.
- Provide facilities and support for the weekly Reverse Referral Service.
- Undertake pathological examination for the majority of requirements at this level.
- Provide for intravenous or subcutaneous rehydration and other emergency requirements.
- Maintain stock of medicine for the SRU and distribution to the VHFs and CHFs.

The training of this new **key functionary**

will have to be evolved based on the available experience of several voluntary organizations. It is not meant to be a mere reorientation of the existing ANM course since the role and functions of the Sahyoginis will be entirely different. Such a course of two years, of which one third will be theoretical at the taluka training center and two thirds practical at their SRU, will need to be conducted jointly by the Medical and Health Components at the Taluka Training Center. This training will have a very strong social component covering all aspects of health and illness care, community organization and involvement, communication, motivational skills, understanding of Panchayati Raj and the functioning of Panchayats levels. Also knowledge of telecommunications and computer, repair and maintenance of basic equipment of the SRU will be provided. Knowledge and technical skills of mid-level medical, surgical, pediatric, midwifery and gynaecology will have to be imparted to these trainees.

The National Open School now offers the opportunity for evolving a suitable nationwide curriculum and training programme for such functionaries, followed by an examination to ensure a country wide uniformity of training for such workers.

A seven-room accommodation for office, examination room, a 4-bed ward, store room, a room for deliveries, septic surgery, infectious cases and a library will have to be provided for the SRU.

The SRU should be located within a central and easily accessible village to make it a community resource and not built outside a village as an alien facility like the present government subcenters. Rental accommodation available in the village should be used whenever possible even if it is distributed at different places within the village.

An important function of the SRU is health education. As such the SRU itself must demonstrate the maintenance of social hygiene and cleanliness in its own premises which is so lacking in the existing subcenters and PHCs. This is the only way to teach and promote public health and hygiene in the community. This must hence be an important part of training and of inspection during the weekly Reverse Referral service, which is explained in detail later.

The Sahyogini, we hope, will be the equivalent of the Licentiate Medical Practitioner as trained and employed during the British Raj to serve all functions below that of the medical and health officer in an independent manner. Two members of the Bhore Committee Drs. Vishwanath and Butt strongly supported the Licentiates as "a well tried and useful institution". In the dissenting note they have clearly stated that "we do not regard the licentiate as "an imperfectly" or "hastily manufactured" doctor. (GOI, 1946). For this adequate remuneration and provision for medicines, supplies and maintenance must be provided in keeping with local village scales and requirements.

The selection and control of the Sahyoginis and SRUs has to be vested in the Group Gram Panchayat and its Sabhas and not with the taluka Panchayat Samiti.

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7

Taluka Level - The People's Health Complex

As stated previously though nutrition, education, water, sanitation, housing and environment are chiefly non-medical fucntions, they are the prime determinants of the health of the community and lend themselves chiefly to the people's own effort with some minor inputs of medical knowledge and technology. Even the important preventive and promotive aspects of medical care which also play a dominant role in determining the health of the community, lie mainly in the people's own domain, but need greater support from the medical component of the Community Health Care System. These components are highly complementary and mutually supportive. Hence the approach has to be of an integrated nature.

Unfortunately it is the curative aspect of the medical component with its expensive high profile technologies that presently commands the interest not only of the medical profession but also of the people. Even in curative medicine, it is the less glamorous yet well established simple knowledge and technologies which are the most cost-effective and hence need the greatest attention. Not being dramatic and of low commercial value, these have unfortunately been relegated to the background in both medical and nursing education and practice. A doctor interested in the non-curative aspects of health is hence a rare commodity. It is unfortunate that the family doctor who served this requirements has been replaced by the glamorous specialists.

The health component

It is essential that for the overall improvement of the health of the community a new cadre of personnel will have to be developed and trained in the wider concept of health and its management with emphasis on involvement of the community itself. The production and utilization of such personnel for the various levels of the Community Health Care System will need the highest priority. It will need a major reorientation of the concept and attitudes towards health by the medical profession, the bureaucracy, the politicians and above all by the people and the community. Highest priority needs to be given to this concept and its various aspects rather than the present narrow techno-managerial medicalised and commercialised approach to solve individual health problems through a bio-medical curative approach. The social, economic, cultural and political aspects must hence form an important component of the training of such a cadre of personnel together with the epidemiologic and basic medical approach. This approach must also be introduced into medical and nursing education rather than the narrow medicalized Preventive and Social Medicine (PSM) department of the Medical Colleges if health is the ultimate objective.

The recent trend of training separate cadres in health management and health economics hardly meets this objective. It has only resulted in developing a new opportunistic cadre under the guise of health for the management of large urban hospitals and for supporting the medical industry.

The new cadre of health professionals

we envisage must be responsible for the effective functioning of all aspects of health of the community of which medical care is only a relatively small though necessary component. Without such a cadre in overall charge of the Community Health Care System, the curative medical services will invariably dominate the entire system. This will also entail a major conceptual change in the understanding of health and redefining the limited role of curative medicine in overall care of the health of the individual, family and the community.

This wider and more holistic understanding of health is a commonsense approach which if adequately promoted can be readily understood and appreciated by the people, the community and its leaders.. Even in our Indigenous Systems, the basic principles of health are reflected in the empirical experiences of the common people. These were called the 'little traditions', which even today are very much part of the overall culture and practices of our people. It is common knowledge that health cannot be attained under the conditions of abject poverty of the villages or urban slums. Under these conditions the majority of our people have no alternative but to seek temporary relief from illness through increasingly expensive, profit-oriented, private medical intervention, especially in the absence of an effective public sector service. The Community Health Care system provides a more accessible, humane and highly cost-effective alternative which is geared more towards health than mere medical care. Only a well informed and awakened people empowered by Panchayati Raj can implement what is in their own interest.

The health component will have to play the key role in such a system if health and not medical care is the prime objective. The following are some of the major functions of the Health Component of the Community Health Care System.

- It will be responsible for guiding and supporting the Panchayats in all matters concerning health.
- It will help devise methods for the appropriate collection, allocation and utilization of funds at each level.
- It will be accountable to the community at every level, from the village and SRU to the taluka/block for all health problems and activities, both non-medical as well as medical.
- It will be responsible for the overall supervision, training, support and coordination of all health and medical staff in order to ensure an integrated approach for achieving optimal health of the community utilizing all available human and financial resources.
- It will provide the interface between the Community Health Care System and that at the District, State and Central levels, and yet its accountability will only be to the Gram Panchayats and their Sabhas and the Panchayat Samiti and its Sabha which employs them.
- A major function will be to create awareness of health-related activities in the entire community and its leaders and encourage people's collaboration and cooperation in all matters concerning their health.
- It will encourage support and reinforce the useful aspects of our traditional health culture and activities, including the use of home and herbal remedies, and use of the indigenous systems of medicine and homeopathy
- It will ensure two-way communication and interaction between all levels of the system so essential for all routine work, training, support and care of epidemics and emergencies.
- It will also ensure adequate availability of infrastructure, equipment and supplies and their maintenance and repairs for smooth functioning of the Community Health Care System at each level.
- A major task of the health component will be to ensure that this new concept of health be conveyed to all inhabitants, including

influential elders and elected Panchayat members. The advantages over the existing system will have to be emphasised. These include practicality, easy access, humaneness, cost-effectiveness, large employment potential of local personnel at each level at relatively low cost, and the absence of problems of unionization and accountability to the community and not to a distant bureaucracy.

- It will encourage continuous monitoring of the functioning of this system by the community at each level as well as their involvement and support.

- It will mobilise the vast potential of the community for participation in allied fields like nutrition, education, water, sanitation, housing and environment. Above all, the importance of the people's role in their own health and its care will have to be stressed.

- It will propagate the new concept of health and medical care and demonstrate how it can be both technically as well as financially more cost-effective, humane as well as self-sustaining. The concept of health and medical care belonging to the People's own sector rather than 'delivered' by the Public or Private Sectors.

Preventive aspects

The Health Component will be responsible for the TRAINING CELL at the Taluka/Block as a part of its activities. It will organize training for all locally recruited personnel at every levels supported by the Reverse Referral Service. The major emphasis has to be on the 'invisible' aspect of health rather than the present medicalized vertical, target-oriented approach for individual diseases operated by the PHC without concern for local needs. This has to be replaced by a regular ongoing concerted action for local health problems which vary from village to village and from season to season. This can be best undertaken by the people themselves as they and their functionaries are most conversant with their local problems as well as the local reality under which they have to operate. Also because they themselves are the chief beneficiaries. This is radically opposed to the present transfer and 'target-oriented' approach of the PHC and its staff over which the community has no control. There is also an almost total lack of coordination between the staff of competing vertical programmes which will be avoided in such an integrated system.

A far more effective way of tackling many of these local problems can be conceived and executed by the community itself. A cooperative 'shramdan' type of approach can achieve superior results at much lower cost as demonstrated by the recent experience of Kerala . The health component of the Community Health Care system can play a pivotal role in explaining the concept of prevention by providing knowledge and expertise and by demonstrating simple, cost-effective alternatives to help the community solve its own problems, using a combination of traditional as well as newer knowledge and technologies. ISM & H have an important role to play in this aspect of health care as they focus more on the mental and spiritual aspects of health. In Ayurveda, with its stress is on health and not mere illness care, has become a part in the lifestyle and culture of our people, making it different from the narrow and more materialistic preventive and promotive care approach of the Western system of medicine which dominate the present health scene. It will not be difficult for our people to return to the roots of their age old culture.

Requirements of the health team

- They must accept that in Panchayati Raj the people at every level are at the helm of all affairs including health. As paid employees all functionaries have to play a supportive and not a divisive or appropriative role.

- Health is only one of the 29 subjects under Schedule 11 for integrated rural

development under Panchayati Raj and curative medicine is only one of the components that determine the overall health of the community.

- Women will have to play the dominant role in most health and medically related activities.

- Social and managerial skills are of far greater importance than mere medical technology where health is concerned.

- It involves understanding the significance and participation in social, cultural, economic and political factors concerning all activities which ultimately determine success or failure of such a People's sector and system.

The health team

This will comprise of the Chief Health Officer (CHO) with a cadre of Health Assistants. The CHO will be in overall charge of ALL health and medical activities of the taluka/block to ensure unitary responsibility, control and accountability to the community. The CHO will be provided adequate staff for training as well as support, especially in the field where the majority of preventive, promotive and non-medical activities have to be undertaken. She/he will be responsible for the training and Continued Education of all functionaries except the few doctor and nurse.

The knowledge and training requirements of the CHO and the staff of the Health Component should comprise of

- Management of personnel and interpersonal relationships.

- Social, cultural, economic and political aspects of rural life and rural development.

- Non-medical aspects of health eg. water, sanitation, environment, nutrition, education, gender issues and health education.

- Basic knowledge concerned with preventive and promotive aspects of health and of curative medicine.

- Epidemiology and statistics.

- Functioning of the Panchayat system and of the Public and Private sectors.

- A sound understanding of the prevalent health, social traditional practices as well as of ISM&H.

- Office management - accounts/audit/ reports etc.

- Finance

- Transport and communications.

- Basic methods of training and education.

- Maintenance and repairs of buildings, equipment and vehicles.

- Purchase of equipment and supplies

The Health Team will comprises of :

Chief Health Officer	1
Senior Health Assistant	4
Junior Health Assistant	4
Administrative staff	4
Drivers	2
Other supportive staff	3
	18

If the health component has to play its key role in the Community Health Care System, a new cadre will have to be evolved and trained within the Panchayat system for this purpose. This will not be possible if the selection is based on the present city-based, university educated individual/s with little knowledge and understanding of the reality of rural India which we prefer to call Bharat. With a few exceptions, such urban graduates fail to adjust to the social and cultural requirements of the rural Panchayat even at the taluka, leave aside the village level. Even

the city trained PSM doctors will try to impose urban norms to which they conform. This has been the major cause of the failure of the PHC under the leadership of the urbanised doctor. Recruits for such training will have to emerge from within the local rural community and its Schools and colleges who will then receive extensive, broad-based and highly practical training for the specific needs of the Health in the Panchayat system. National Open School which has a rural orientation and is available in 14 languages, can help to train such a new cadre of Health related professionals for functioning at various levels. This will ensure a uniformity of training. S/he will be a paid employee of the Panchayats and whose major activity and time will be spent in the field interacting with the people and their health functionaries than in a taluka office.

The Panchayat will provide facilities, resources and support to this health component on a high priority basis in order to ensure the health of the entire taluka with accountability to the people at all levels.

The medical component

No health programme can succeed unless the curative component, which is the felt need of the people, is adequately provided for. The medical and nursing profession by training and practice are chiefly oriented and interested to allopathic hospital style, curative medicine and hence is most comfortable while serving this requirement. Unfortunately their education is not compatible with the overall health requirements of the community, and especially of rural India since this encompasses a much wider universe. Both these professions have marginal interest in the preventive and promotive aspects of medicine, leave aside the even more important non-medical aspects that affect the health of the community. This is also demonstrated by the low priority given to Preventive and Social Medicine in medical education which in turn also fails to appreciate the social, cultural, economic and political dimensions of health and medical care.

The Community Health Care System at the village level with its graded supportive referral service can not only look after the non-medical aspects of health but also the majority of the preventive, promotive aspects of medicine. Contrary to common belief they can also cater adequately to over 80% of the basic curative needs within the community itself. Since the PHC has failed to provide any meaningful curative and only a spasmodic preventive and promotive service, it is necessary to strengthen these functions at both the village level and that of the Satellite Referral Units (SRU) at the 5000 level while also providing a high level of supportive Health and Medical services at the taluka level.

Such a decentralized curative medical service needs the back-up of an efficient hospital-based service. Only this can give credibility to the People's Sector. With the provision of an efficient communication and transport service between the village, the SRU and the block/taluka hospital, a comprehensive and cost-effective curative service can also be provided even for most of the major problems (including care of all emergencies) up to a hospital level inclusive of specialist medical and surgical care. This system must also provide a regular weekly medical Reverse Referral service at the peripheral levels. Such a system would leave only a few problems requiring tertiary super-specialist services and facilities available only at the District and City hospitals. It would also reduce dependence on an increasingly expensive and not so effective private sector which presently operates at all levels. Such a decentralised well-integrated graded multi-level system of medical care from the village and SRU would also prevent unnecessary overload of the services at the taluka People's Hospital. The availability of adequate funds for such a decentralised system has been explained in the chapter on Costing.

As a result of improved living conditions in taluka townships, it will now be possible for most Panchayats to attract urban-trained

doctors and nurses even up to the specialist level. Conducive conditions of work offered by a well-equipped hospital together with adequate remuneration may be a better option for them than opening private nursing homes which are now sprouting in most taluka townships. The urban cultured and trained doctor and nurse who have failed to provide service and leadership at the level of the village PHC will be happy to serve at the People's Hospital due to the 'push and pull' effect now operating between the city and the Taluka. The gross over-production of doctors and nurses, paucity of jobs, high cost of establishing private practise, pressures for earning through malpractise and resulting legal action, the difficulty and expense of children's education, of social life, of transportation and pollution in cities provide major attraction for the Taluka township.

The People's Hospital operated by the Panchayat will also be very different from the frustrating experience of the Community Health Centres (CHC) of the present Government system. They were established on the recommendation of the ICSSR/ICMR report but without understanding the social, bureaucratic and political implications that need to accompany it. The People's Hospital, being a part of the Panchayat, will no longer be an impersonal institution operated by a distant State bureaucracy. It will be a well-equipped people's institution with administrative and financial control vested with their Panchayat. There will be strong self-interest within the community in ensuring that such a hospital functions efficiently, free from the red-tapism, delays, transfers and targets which plague the existing system. Devoid of financial considerations of private practise this will help restore the doctor-patient relationship which is the greatest reward of the medical and nursing profession which has been eroded lost in both the public and private sectors. The fear of doctors and nurses being harassed by less educated local leaders is based on the experience of the present CHC which is an alien institution where the people have little interest or say in its functioning. No local leader would dare to browbeat a doctor or nurse who serves the community with love and concern, for in a well functioning Panchayat system people have the ultimate say and would not tolerate such arrogant and irresponsible leaders. Adequate remuneration at the prevailing market rate, facilities of a well-equipped and well staffed hospital together with job satisfaction should pose little difficulty in attracting and retaining doctors and nurses even upto the specialist level, in preference to opening private nursing homes at considerable cost where they have to work all hours of the day and night.

It will be in the interest of the people and of the Panchayat functionaries to ensure adequate financial support and smooth functioning at each level of the Community Health Care System since they will be the beneficiaries in terms of quality medical care at lower expense.

At present 80-90% of expenditure in the public sector hospitals is incurred on salaries. This will be reduced to about 60%, since all staff other than the few doctors and nurses will be recruited and trained from within the local population and paid salaries commensurate with local scales, rather than the inflated rates sanctioned by the Pay Commission under pressure of the unions. This would ensure availability of adequate resources for medicines, supplies, transport, repairs and maintenance which is so lacking in the present system.

Like any hospital the People's Hospital would provide all necessary facilities and services such as pathology, x-ray, blood transfusion, in addition to outpatient and inpatient medical and surgical care up to the broad medical and surgical specialist level.

To ensure that the People's Hospital provides good medical and surgical care, the following staffing pattern is indicated in keeping with reasonable finance inputs.

1	Physician (allopath or ISM&H trained)
1	General Surgeon
1	Gynaecologist
1	Anaesthetist
6	GDMO (3 from ISM&H)
3	Nurses
15	Nursing Auxiliaries (Sahyoginis trained for hospital work)
3	Technicians (pathology, x-ray, sonography etc.)
1	Pharmacist
6	Ward attendants
4	Other Staff

Adequate staff must be provided to ensure adequate of services at all times. The People's Hospital will also encourage 'substitution' in each category of staff eg., surgeon and gynaecologist, physician and General Duty Medical Officers all of whom are trained in medicine and surgery; also among the technicians. One medical specialist will be from the allopathy ISM&H system and out of the six GDMOs three will also be from ISM&H. This will ensure the use of all systems of medicine. Since all of them have four years of training in basic medical sciences in addition to their own systems, cross practice of basic techniques and drugs should be permited and encouraged. The anaesthetist will also train all other doctors and nurses in the practice of basic anaesthesia and resuscitation.

All staff other than the externally trained doctors and nurses will receive two years initial training at the taluka Training Center. This will be provided by the doctors and nurses as initial as well as continuous training for the specific requirements of this hospital. This will ensure the guru - shishya relationship which is so important in our culture. Except for the theoretical aspects of training, the majority will be highly practical on a 'hands-on' basis in the hospital itself, both aspects being conducted concurrently. The adjacent 'Training Cell' at the taluka level will provide the necessary requirements for such training, including multi-media for distance education.

Technicians will be trained in all fields eg. pathology and x-ray as also in maintenance and basic repairs of their equipment. Training will give due attention the non-medical social, cultural, economic and political aspects of health.

The majority of the non-professional staff who will be locally recruited and trained will not require residential accommodation. The doctors and nurses will also be encouraged to rent suitable local accommodation. This will help integrate them with the local community; a cheaper and more effective alternative to building separate staff quarters which isolate them from the local community of which they must become a part.

A major function of the People's Hospital will be to ensure adequate functioning of the medical services of the entire Panchayat System upto the village level. This will include the training of all functionaries undertaking medical care at each level ie. CHF, VHF and Sahyoginis at the SRU and hospital. This will ensure continuity of medical care from the village to the taluka hospital. The weekly Reverse Referral service offered by this system will be an important function of the Medical component undertaken in tandem with the Health component thus ensuring coordinated approach to both health and medical care. Adequate number of general duty medical officers as also transport is provided for this important function of the medical component of this service.

Most of the bulk drugs for the hospital, the SRU and the village level will be purchased at the taluka level. Functionaries at the village level will also be taught how to purchase common drugs and supplies to avoid over-centralization of the system. Wherever possible drugs will be purchased in bulk under their generic names ensuring good quality at reasonable prices.

A major handicap of the existing system is the over-burdening of the referral chain with problems which do not require their expert services. This diverts time and attention from

those who really need such professional attention. Hence in the Community Health Care System, apart from emergencies, all cases coming to the referral unit whether it be VHF, SRU or hospital must be screened by the next lower functionary/unit. Except in emergency direct approach to a higher level must be discouraged. Hence a next lower level service station must be adjacent to every referral unit. For example a SRU must be in proximity to the hospital, and a VHF next to the SRU. Those who bypass the referral system and go directly to a referral center must be charged adequately (as in the private sector) to dissuade this practise. And yet if a patient starts with a CHF and is referred even up to the taluka hospital s/he will pay no extra charges to that of the CHF.

Under these conditions a 40-bedded hospital extended with a dharmashala can meet 95% of all medical and surgical needs of 100,000 population in a highly cost-effective and humane manner. Though the Bhore Committee recommended a 75-bedded hospital for 20,000 population yet the Community Health Care System proposes a 40-bedded hospital, as it is felt that there will be preventive care, early detection, as well as a number of cases will be tackled by the Sahyoginis, thereby reducing the need of hospitalisation. Also the Hospital can be expanded by the 'dharamshala'.

The Dharmashala - In actual practise the need for utilization of an expensive hospital bed is only during the acute stages of disease. The major reason for occupancy of a hospital bed is for observation of acute cases, during the acute stages of medical and surgical treatment and during the immediate recovery period. The rest can be attended to in a nearby dharmashala for those requiring observation or those who cannot return to their village till the problem can be safely returned back to the SRU or VHF.

Since space is readily available in rural areas the provision of a simple shelter where the patient and his/her relatives can live at clean floor level and have basic cooking, bathing, toilet and other facilities needs to be provided. This would reduce expensive hospital bed occupancy to about a quarter of its existing level while the staff are readily available for daily supervision and help.

This also provides a cheap and humane service where the relatives can cater to the routine care of the patient including providing food and nursing care. Local rental accommodation available in the taluka township can also be utilized if desired by some.

The dharmashala not only reduces need for staff but also the cost of transport to patients and relatives. With the availability of peripheral service at the village and SRU, together with the Reverse Referral service, earlier discharge is possible even from the dharmashala with a note to the local village functionary. The occupation and turnover of available hospital bed can be multiplied two or three fold with an additional cost of about 15% of the average hospital bed cost.

In such a decentralised system the people will have access to quality medical care in a graded manner. The Reverse Referral Service helps to identify patients requiring hospital care and also permits follow-up as near their home and in a personalised manner. The load on the more expensive district and tertiary level hospital will thus be drastically reduced and allow them to concentrate on more specialised services for relatively fewer difficult problems. This will enable reallocation of health resources from urban to rural areas. The Community Health Care System with its People's Hospital will directly influence the quantity and even quality of care in the private sector which will have to improve its services and regulate its charges. A far more effective means than external policing and legal action against this profit-oriented sector.

It is estimated that the size of such a People's Hospital should not exceed 30 or 40 beds in the initial phase. This may increase

eventually to twice the number resulting from demands of a more enlightened public prefering to incur expenditure on such cost-effective public sector facilities rather than in the private sector.

Such a People's Hospital will be similar to the County Hospital of the UK operating during the middle of the past century. Such hospital provided efficient personlized care to its own county under the existing social, cultural and economic conditions in a far more personalised manner than large distant mega hospitals. Many such countries after experimenting with over-specialised care are returning to this mode of medical care and small hopitals.

The People's Hospital will function like any hospital of similar size with the following proviso:

- It will cater to the needs of the rich as well as of the poorest on an equal basis.

- Emphasis will be on quality services for the common medical and surgical problems, utilizing the most safe and cost-effective available technologies rather than the 'latest' expensive ones promoted by the health industry.

- Use of all available systems of medicine with choice left to the people.

- Private practice and employment of part-time or honorary basis must be strictly prohibited for all personnel. It is far better to pay higher scales than privatize such institution under private government and international pressures under the guise of cost-efficiency. Privatization of any sort will doom the entire services of the Panchayat System where profit and service to those who can pay will dominate basic health and medical services to the poor. There can be no more cost-effective and humane care for all citizens than provided by the Community Health Care System where health and not personalised profit-oriented medical care will be the dominant consideration.

- Accountability will be to the local community and the Panchayat and not to the State or Central bureaucracy which can provide support as and when required.

- A restricted number of drugs will be employed wherever possible and under generic names.

- Strict social hygiene will be maintained within and in the precincts of the hospital and health centres.

- Patients' relatives will be encouraged to participate in patient care.

The training component

The teacher-trainee relationship in the Indian culture develops into a life long emotional bond. A closely integrated decentralized system confined to an area like Block/Taluka utilizing locally trained personnel who are not subject to transfers and target pressures provides an ideal opportunity for building of such an intimate relationship between all levels of functionaries which is absent in the existing impersonal bureaucratised system. In the Community Health Care system there is also an inbuilt motivation of caring for the people who are not mere statistical figures but personally known if not related to the staff. The caring human relationship of such an enlarged and extended family also ensures accountability at all levels not based on supervision but assisting each other for serving their own people. No amount of technical and managerial training provided in an impersonal distant District Center can achieve this. Training within the area of work also has the added advantage of relevance to the local conditions and requirements. This has been lost in the present public and even private health sector, though the latter provides a more personal relationship if only for profit.

Except for the few urban trained senior health professionals like doctors and nurses the rest of the staff of the entire Community Health Care System will be trained within the Community Health Care system itself for functioning at every level. Both the initial as well as later continuous training is undertaken as close to the place of work as is feasible. Training and practise is hence an integrated process and maintaining an uninterrupted teacher-trainee (Guru-Shishya) continuum and bond. The Reverse Referral aspect of this system where teacher and trainee meet and discuss practical problems and experiences every week is an important part of maintaining close communication, training and bond between all levels of functionaries.

The training for the various categories is broadly as follows :

- Continuous education for the senior personnel, i.e. doctors, nurses and health staff is chiefly a process of self-education through regular meetings and discussion sessions supported by adequate facilities of a library, audio visual teaching, utilizing the advantages of Distance Education provided by the National Open University and by deputation to professional conferences and meetings. They must also participate in joint discussions with the active citizens and the rest of the staff.

- The initial training of the locally recruited staff consists of a combination of theory and practical sessions followed by continuous education of all functionaries at every level.

- Initial training of the 80 Sahyoginis functioning at the 20 SRUs is for a period of two years. This will alternate between short periods of theoretical training at the Taluka Training Center (TTC) and practical experience at their own SRU. The four Sahyoginis at each center will permit such training at the Taluka Training Centre (TTC) in a staggered manner without disturbing routine work. This will be reinforced by the weekly Reverse Referral visits of taluka based Health and Medical staff to each SRU.

- An annual or biennial meeting of all the health and medical staff held at the taluka or other convenient place within the Taluka/Block helps to maintain unity and espirit de corp of all functionaries of the system. Active citizens or concerned citizens must also be encouraged to attend these meetings.

- Training of the VHFs and CHFs, bar short visits to the TTC, is chiefly undertaken by the sahyoginis of their own SRU followed by routine weekly visits of the sahyoginis to their village. This is also a part of the Reverse Referral system at this level.

Members of the community should also be encouraged to participate in such training sessions and meetings to help them develop confidence in their own workers and also to increase their own knowledge and hence supportive role in all activities concerning their own and their community's health. Such training sessions should be held in an open space like a temple, community hall or under a tree where the community can attend and even participate.

Next to selection and control, it is training that plays the important role in the effective functioning of the Community Health Care system at all levels. The present government method consists of giving a large single dose training in a distant District Training Center. While this is convenient for the bureaucratic structure, by its very nature it is didactic and theoretical rather than practical for the entirely different requirements of the rural community in which they will eventually work. The emphasis of such training is on technology and administrative functions for achieving 'targets' of the various national programmes. Important subjects like communication skills, community involvement, social, economic, cultural and political considerations that play a major role in successful implementation of the knowledge, skills and technology receive little attention.

Such training is devoid of the reality at the grass roots. The ANMs are trained more as hospital nursing auxiliaries than functionaries for operating within and with their own village community. Such training for passing an examination to secure a job is seldom followed by meaningful continuous education. There is little rapport between the teacher and trainee in such a formalized and bureaucratic set-up.

The training of all personnel of the Community Health Care System has to be local, specific and highly practical in its nature in order to serve the needs of the people and their local Panchayat institutions from the village to the taluka/block. Their accountability is to the local community which selects, employs, supports and pays them and of which they and their families are a part.

Taluka training centre

Taluka training centre (TTC) is an important component of the Community Health Care System and is located within the People's Hospital and Health Centre Complex with class rooms, library, audio-visual and other teaching and training aids. Also for the use of the National programmes for Distance Education for all levels of functionaries. The TTC should be able to cater to a residential group of 20-25 students at any given time. Under the overall management of the Chief Health officer this training cell will provide

Induction training of about a week for introducing the concept of the Community Health Care System to all new entrants as well as Panchayat members.

Initial training to various cadres - both medical and health. The duration will be tailored for the requirements at every level in batches of from 15-20 trainees in a participatory mode in the form of discussion and demonstration of which the teacher is a part. Such training is best undertaken seated in a circle on the floor as this is in conformity with the rural culture. It overcomes the hierarchical nature of classroom lectures and must be in the local language. It must attempt to demystify health and medical care, encourage self-help and appropriate use of all available referral services.

Continuous education will be at weekly sessions for about 2 hours at the Training Center for Taluka based staff. For the rest it will be chiefly as a part of the weekly Reverse Referral visits of Health and Medical personnel to the SRUs. The SRUs in turn will provide both initial as well as continuous education to the village based personnel. This will be an important part of Sahyogini training. All locally recruited staff will have to pass a final test before confirmation of appointment by the Panchayat at each level.

All members including doctors, nurses and senior Health staff will be expected to spend at least two hours per week for ensuring continuous education. This will require staggering of the staff duties for such continuous education to ensure uninterrupted routine services.

The use of relevant Distance Education programmes and the material that is provided therewith can be utilized during such training for all staff including doctors and nurses. This will also help ensure a uniform standard of education for all personnel at every level throughout the country. The Panchayat will bear the expenses for such education for all staff as a part of its health activities.

Principles for training

Except for the few doctors, nurses and senior health personnel all functionaries of the Community Health Care System from the village to the taluka will be selected by and trained within the community. Almost all communities in India can now provide women with the necessary basic education and motivation for each level of the Community Health Care System. Lack of educational level can often be made up by the motivation to serve and improve their status for there is no

dearth of motivated intelligent women in our country. The National Open School can provide basic education even to illiterates. The bureaucratic method of giving preference to higher educated persons in selection of candidates, more often than not, proves to be counter-productive because the present type of formal education inculcates knowledge and values which are different from the problem solving requirements for functionaries serving the actual needs of the people. Over-educated personnel often migrate to the urban centres.

In such a system all functionaries enjoy the same status, for this is not related to any education level, extent of training or remuneration. Their status depends on the service which they render to their community; very different from the present hierarchical system.

- Such training provides opportunity for advancement eg. from CHF to VHF and to Sahyogini up to taluka Health and Medical Centre. Integration of social and technical content of training ensures sensitivity and respect for the peoples culture, local knowledge, practices and values.

- Strengthen good local practices and never denigrate them. Teach maintaining of simple records chiefly for self-use and help towards an epidemiologic approach to problems. Maintenance of accounts, charges, receipts etc. should be a part of training.

- The training must be of an integrated nature for all activities and should not be confused with unnecessary and inessential details which they can learn later on their own.

- It should employ a problem solving approach which should be as practical as is feasible.

- How to utilize available referral services-public and private besides those of their own Panchayat system.

- Other methods of communication and community organization like songs must be used. Also how to conduct group meetings and other activities to develop a sense of togetherness, strength and mutual exchange of information among trainees and also the community. All in an informal manner.

- Audio visual aids must be limited and specific. Non-course activities undertaken like music, sewing etc. can keep up interest.

- The rate of development varies with individual trainees.

- The place of training must be convenient to trainees and not merely for those who teach.

- The message at each session must be short and precise followed by discussion. Breaks at regular intervals are important to keep attention and to maintain an informal atmosphere between teacher and students. Sharing at meals is a useful social activity between teacher and those who are taught.

- Visits to other institutions help to stimulate interest as well as meetings at different villages whenever possible.

- Groups should not exceed 15-20 participants to enable better participation and discussion.

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8

The Reverse Referral System

It is well established that village women given appropriate training are able to undertake many of the functions which have hitherto been the purview of the medical and health professionals. They have the advantage of close social, cultural and physical proximity and accountability to the people. The difference in undertaking tasks such as malaria, ARI and tuberculosis by local health functionaries as compared to the five-year trained doctor lies in the level of confidence generated by prolonged and expensive training much of which is of an academic nature for tackling the relatively few problems that are beyond the capacity of the paramedical.

To a great extent this can be overcome by training local village women eg. CHF and CHVs to diagnose, or failing that to suspect problems. When necessary these can be referred to their Sahyoginis who in turn can refer to the professionals. The need for such referrals decreases with increasing confidence gained by experience. Yet in a field like medicine the extent of risk needs to be minimized if professional advice can be obtained either by personal contact or even if available through telecommunication and\or even by the use of a computer with appropriate software in the local language.

Another highly effective way to overcome the confidence gap is the use of the Reverse Referral system operated between functionaries with different levels of training, knowledge, skills and facilities. This is best demonstrated between the professionals at the Taluka/Block level and the Sahyoginis at the Satellite Referral Units (SRU). A weekly visit by a joint team of Health and Medical professionals from the Taluka Health and Medical Complex to each SRU would not only serve this purpose but also provide continuous hands-on practical training to the Sahyoginis and the Village Health Functionaries. It would also reduce the need for a large number of patients to be unnecessarily referred to the Taluka Center since professional expertise will now be available at the village level. Except for emergencies most medical as well as public health problems can be tackled in this manner and the confidence of the people in the entire system can be increased substantially. This would also ensure that the professional staff will remain aware of the problems of the villages and their inhabitants which is virtually absent in the existing system.

While locally trained village health functionaries can undertake majority of medical problems such as ARI, diarrhoeal diseases and malaria on their own, in a field like medicine, the confidence of such health workers as also of patients depends on the extent of training and availability of referral support when diagnosis or treatment is in doubt. Unfortunately the availability of the five-year trained doctor at the village level is not possible nor constantly required. It also increases the cost of care to an unacceptable level as demonstrated by the private sector.

The graded referral and supportive services of the Community Health Care System

together with improved telecommunications and transport can substantially help to overcome this difficulty. The middle level training provided to the Sahyoginis at the SRU can to a great extent overcome this difficulty within the villages themselves.

It is for operating such a Reverse Referral Service that adequate number of General Duty Medical Officers (GDMOs) and of Health personnel must be provided for. Adequate transport has also to be provided which may seem excessive but is of importance for maintaining a regular Reverse Referral System as also for emergencies.

Intra and inter sectoral collaboration has been emphasized in the public sector but has seldom functioned in actual practice even within the health system. The Reverse Referral System provides a new meaning to this concept of intra and inter sectoral collaboration. In actual practice, a team comprising of one medical GDMO and one Health trained person will visit two SRUs every day. This will enable them to give local advice or refer problems to the taluka level as and when necessary. They can also follow-up on patients previously treated at the taluka hospital. This will also provide an opportunity for hands-on training of the Sahyoginis and even CHFs and VHFs at the SRU. This same Reverse Referral service will also operate at each level between VHF and CHF and the Sahyoginis of the SRU to increase their knowledge, skills and confidence.

The Reverse Referral System bridges the gap between the level of professional expertise and the social and cultural expertise required at the peripheral levels.

Such a Reverse Referral Service should also operate between the District and Taluka services.

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9

Functional Classification of Diseases

Classification of diseases is necessary for diagnosis as well as treatment. While diagnosis must theoretically precede treatment, in the majority of cases when the patient first consults the doctor, treatment is chiefly on a symptomatic basis unless there is need for emergency intervention. Treatment is chiefly on the basis of history of the complaint and simple clinical examination.

Such an approach is not only time and cost effective for both patient and doctor but also avoids unnecessary apprehension, transport, investigation, and medication. What the patient most needs at this stage is assurance and information as to when and how to seek additional advice and/or treatment in the unlikely event of this being a prodromal symptom or sign of a more significant disease. In actual practice waiting and watching is one of the most important tools in the medical armamentarium.

The degree of confidence with which an ailment can be diagnosed and managed depends on the nature of the disease and the knowledge and skill of the physician. The available knowledge and technology for its prevention, treatment and control is also important since this varies greatly in cost and effectiveness with different diseases at its different stages. It also depends on the individual's and nation's resources, which can be the predominant factor in countries where the overall health manpower, public and personal resources are limited. This constraint also operates among the poor sections in affluent countries where health services in the public sector are restricted. Even in a country like Britain, with an excellent National Health Service, the burgeoning cost of health care due to the promotion of unnecessarily expensive new technologies necessitates that the utilization of available medical manpower and resources must be optimised for the benefit of all citizens. This has been achieved by encouraging self-care and the use of paramedics and nurses for help in the home to reduce expensive hospitalization, also in the hospitals themselves. This relieves the load on the more expensive general practitioner, hospital and specialist services to the extent possible. Expensive investigations and services also have to be rationed.

Such a graded form of health care is not only cost-effective, but humane and socially more acceptable as it permits intimate interaction and caring between the patient, and the local health functionary, which is often lost in the increasingly impersonal high-technology oriented medicine. While desirable in a country like Britain, there is no alternative to such a graded system of care in a country like India if health care is to reach the majority of our people, especially those who are dispersed in the 700,000 villages. The increase in the number of allopathic doctors from 62,000 in 1951 to 484,000 in 1997 (GOI, 1998-99) has failed to solve the problem while increasing the cost of health and medical care and consequently placing it almost out of reach of the 36% who are below the poverty line. (GOI, 2000).

It is hence necessary to evolve a more functional classification where diseases are classified not according to medical pathology but according to the varying levels of knowledge, skills and facilities needed for their diagnosis, management and care. Experience of health care projects such as our own at Mandwa (Antia, 1986) has demonstrated the advantage of differentiating diseases by utilising such a practical and functional approach.

Functional Categorisation of Diseases

Diseases can be broadly grouped in the following four categories :

Category A - These comprise of simple, self-limiting diseases which can be adequately handled by the individual and the family e.g. minor coughs, colds, diarrhoeas, bodyaches, cuts, bruises, boils, minor allergies and a host of everyday conditions. Both the diagnostic as well as the treatment skills are a part of the tradition of most families and communities and are managed by utilising home and folk remedies and/or safe and cheap over-the-counter drugs. Also the role of these as a placebo should not be under estimated.

Category B - These are diseases which are not life threatening but are nevertheless responsible for a substantial part of the community morbidity load. These include scabies, worms, moderately severe cuts, bruises, abdominal colic, osteoarthritis, chronic dermatosis, common fevers, chronic obstructive pulmonary disease. They can be adequately diagnosed and looked after with the help of a properly trained local health functionary with a modest repertoire of safe but effective drugs. Advice for management of the disease by methods such as ORT, steam inhalation or how to apply sulphur ointment or benzyl benzoate, would be even more appropriate than unnecessary investigations and medication with antibiotics and corticosteroid which is now common practice, often by injection.

Category C - This category comprises diseases like severe gastro-enteritis, dysentery, acute respiratory tract infection, tuberculosis, tetanus, leprosy, malaria, poliomyelitis, measles, pneumonia, rheumatic heart diseases and sexually transmitted diseases. They are still the major killers and maimers in the tropics despite the fact that we have effective knowledge, technology and the means for their prevention, treatment and control most of which is remarkably simple, cheap, effective and safe especially if detected and treated in their early stages. The medical profession however has revealed its inability to control these diseases despite monopolizing health care. A variety of experiences such as at Mandwa, Banaswari ashram and Jamkhed have revealed that even these diseases can be most effectively tackled by the people themselves in conjunction with their better trained paramedical workers like Sahyoginis if access is available to professional advice and support (Antia et al, 1993). The problem therefore lies not in the inadequacy of medical science and technology or their availability but the inability to reach what is available to the people through the existing over-bureaucratised and over-professionalised health system in both the public and the profit motive of the private sectors. Five decades of experience under the prevailing conditions demands that this can only be attained through the community's own efforts, utilizing graded levels of community-based paramedical workers. They in turn, must be taught and supported by the medical profession with adequate facilities for diagnosis and treatment after confirmation of diagnosis. Withholding simple and readily available knowledge and technology merely because of the dangerous consequences of these diseases, especially if not diagnosed and treated in the early stages and a few untoward complications of the disease or reactions to drugs, has proved highly counterproductive.

Many of these diseases can be prevented by focussing on education, nutrition, environment, water, sanitation and immunisation of the high risk groups within the community itself. Even diseases like tuberculosis and leprosy can be readily

suspected by trained community health workers and their paramedics and referred to the doctor for confirmation of diagnosis. The prescribed treatment regimen can then be effectively delivered and supervised by the local health workers, and the patient referred back for occasional checkup or complications of the disease or drugs if any. This is the essence of the Direct Observed Treatment of WHO which can be carried out more effectively at no additional cost far better than by special government personnel. In situations like tribal areas where medical help is unavailable, the community's own trained workers must also be taught about the few diseases which are responsible for the major mortality and morbidity and their treatment with drugs like chloroquine, sulphonamides, metronidazole, and ORT. They must be taught when to provide first aid and refer if the seriousness of the condition so warrants.

The role of the medical profession must therefore be that of training, guiding, encouraging and essentially of a supportive nature. Professionals, however highly trained have clearly demonstrated their inability to prevent, detect in the early stages, control or treat such problems even at far greater expense. This is often difficult for them to understand and accept, in view of the highly personalized, urbanized and curative nature of present day medical education and practice. The remarkable results achieved by tribal mothers in reducing the mortality of their children from Acute Respiratory Infections (ARI) in the absence of any form of organized medical care as shown by Dr. Bang is a vivid demonstration of such an alternative under the prevailing conditions.(Antia et al, 1993)

Category D - This group comprises high profile but relatively few conditions which need knowledge, skills and facilities that can only be provided by the trained medical or nursing professionals at a hospital. These include major medical and surgical problems and emergencies which are beyond the scope of the paramedical worker who can nevertheless be taught to provide first-aid before referral, as well as to undertake follow up and after care. Early diagnoses by such workers of diseases like cancer, tuberculosis and leprosy, can greatly reduce the load and expense for professionalised treatment beside reducing unnecessary suffering. This is far more humane as far as the patient is concerned and also far more cost-effective.

The Block\Taluka hospital can meet this requirement more effectively and humanely, at far lower cost than at a distant district or city. This would also reduce dependency on unnecessarily costly care in a private hospital.

It is realised that while utilizing such a classification in a few problems in each of these categories the severity of the disease may increase and upgrade it to the next higher category or categories. A holding period of 48 to 72 hours is generally indicated following which persistence or exaggeration of symptoms indicates referral to the next level of care. The paramedical workers can be taught the signs and symptoms of common emergencies like meningitis, abdominal pain or injury where immediate referral is necessary when in doubt. Adequate communication and transport is an important aspect of such a decentralised system of health and medical care so lacking in the existing system.

The Rationale for this Classification

Such classification may seem to smack of over-simplification and even dangerous practice to those who work in our cities or in countries where quality medical services are readily available to all. Yet a similar attitude by the medical profession under conditions, where even elementary medical services are inaccessible to most citizens, is highly counterproductive because it denies available simple but effective medical knowledge and technology within easy access to the majority of the people at a cost which the patient as well as the community and country can afford. This approach also leaves relatively few

problems requiring greater knowledge, skill and facilities for the medical profession who can then devote much more of their time as well as limited expensive resources for secondary and tertiary care which is their interest and for which they are trained. The risk of not utilising such available knowledge and technology far outweighs the danger of withholding it under the plea of safety, not only under the prevailing circumstances but even when the socio-economic conditions improve.

The present approach has only succeeded in mystifying health and medical care and placing it only within the reach of an affluent minority who can afford to pay for services or through influence monopolize whatever effective services are provided in the public sector. The medical profession which in recent years is increasingly perceiving medicine as a prestigious, comfortable and lucrative business has also mesmerised itself into believing that "West is Best". It has alienated itself from its own Indian culture, health systems, traditional folk remedies and the masses. The result is that the profession has made itself believe that there is no alternative to the present system, despite the present system proving to be highly counterproductive. The pharmaceutical and medical instrumentation industry, since profit is its sole motive, has spared no effort in reinforcing this belief among the professionals as well as the public, that modern health care must follow the latest Western pattern however expensive and inappropriate it may prove even in the countries of their origin. Unnecessary sophistication, over-investigation and over-medicalization is a danger faced by those who seek the profit-oriented private medical sector. (Jima, 1994)

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Some Common Medical Problems

The following provides an indication as to how major problems can be looked after at the different level of the Community Health Care System.

Communicable diseases

Diarrhoea - Diarrhoea is the commonest water borne disease and results in profuse watery stools. Of sudden onset it generally occurs at the beginning of the monsoon season or in summer when water sources are dry and polluted. Most of these are of viral origin while some are of bacterial origin of which cholera is the severest. Though both are of short duration of two to three days, the danger to life is from dehydration. This can be prevented in the majority of cases by the CHF administering locally made Oral Rehydration Therapy using salt, sugar and water or with rice water and kanji starting as early as possible. If vomiting or dehydration is severe, intravenous or even subcutaneous saline in infants can be provided at the SRU by the Sahyogini. More important, she also alerts the entire Health team of the Block/Taluka of the epidemic. Cholera needs administration of an antibiotic like tetracycline. Only very few severe cases need hospitalization since intravenous rehydration is possible at the SRU level.

The major function of the Health team at every level is to use an epidemiologic approach to identify the polluted source and alert the community to treat the source eg. the well. Attention must also be directed to the end user point within the household either by chlorination or by heating the water to 65^0 for 15 minutes (Antia, et al 1991). The community has also to be alerted to the need for and technique of early oral rehydration therepy.

Dysentery - This needs to be differentiated from watery diarrhoea. Dysentery is marked by blood and mucous in the stools, tenesmus and toxaemia. Treatment involves rehydration as well as simple allopathic medicines and/or therapy of other systems eg. Kuda in Ayurveda. Contaminated food is the major source of dysentery. Hence stress must be laid on community awareness and cleanliness. Flies are the major carrier.

Both the above conditions are eminently suitable for community action at the village by the CHF/VHF supported by the SRU using cheap readily available and effective preventive, promotive and curative measures.

Malaria - Malaria is caused by a blood borne parasite transmitted by certain species of mosquitoes. It was the commonest cause of fever and death before Independence and was virtually eliminated in 15 years by the concerted effort of the people supported by a small band of equally motivated public health doctors. Unfortunately there is reemergence of malaria of both the milder vivax as well as the more virulent falciparum variety which can cause death from 'black water' fever or cerebral malaria. There is also emergence of

resistance to the cheap synthetic drug chloroquine. The large scale elimination of malaria after Independence reveals the crucial role of the people themselves in solving this major health and medical problems if encouraged and supported with simple knowledge and technology which can be taught to them by their own local health functionaries. This also demonstrates how a vast public and private health system has failed to achieve results at far greater expense when the people are not involved in their own health and medical care.

It is common knowledge that fever with rigors alongwith severe bodyache which recurs at regular intervals and affects several members of the community together with the emergence of mosquitoes is very likely to be malaria, especially if there is no other cause such as common cold or flu. A wait and watch policy for a couple of days can help in confirming diagnosis from such diseases which also commences with similar symptoms. The treatment of malaria involves the taking of a finger prick blood smear for examination under the microscope for parasites in the red blood cells, and simultaneous administration of chloroquine a readily available, safe and cheap drug. Blood smear can be undertaken by the VHF. The Sahyogini can also undertake the microscopic examination of the smears. The intense body ache can be relieved by a simple, cheap and safe pain killer such as paracetamol. Children with very high fever need body sponging with water. If the smear is positive or the fever persist over five days the patient must be referred to the doctor. If associated with severe headache and drowsiness, emergency transfer to the People's Hospital is required. The village local health functionaries are trained to observe and take such prompt action.

More important is the need to prevent the disease through control of the breeding of the mosquito and its larvae in pools of water. This is best undertaken by the entire community, including school children rather than by a malaria technician who visits at intervals. Small breeding pools can be sprayed with oil and/or insecticide as also the spraying of the interior of houses using the pesticide sprayer used for agriculture which is available in every village. An expensive bureaucratised vertical malaria programme has failed to achieve what the people were able to on a far larger scale when activated. This is because they have greater self-interest in the control of the disease and can mobilise a vast number of self-motivated individuals at no cost. The Block/Taluka Health and Medical Center can provide them the necessary training and expertise as also drugs and insecticides as well professional support for complications.

Such people operated control measures can also be part of an integrated vector control programme for the simultaneous control of other vector borne diseases like filariasis, kalaazar and viral encephalitis at relatively low cost, which more expensive vertical programmes designed for each of these diseases cannot achieve at far greater expense. This was demonstrated by the ICMR study on 'Integrated Vector Control' (ICMR, 1989).

Tuberculosis - As a major cause of community morbidity and mortality, tuberculosis is both a disease as well as the most sensitive indicator of poverty for it is intimately associated with malnutrition, poor housing, delayed diagnosis, inability to seek medical aid and ensure prolonged treatment. The Panchayat as a part of the country's political system can help to tackle the basic underlying social and economic factors which the present medicalized approach fails to address. The Community Health Care System also provides the means for suspicion, confirmation of early diagnosis and for ensuing continuous treatment at low cost. It protects patients from the high cost treatment of the private sector which neither cures nor helps to prevent the spread of the disease among the family and community while impoverishing the patient and family with unnecessary and expensive x-rays, diagnostic tests and medicines but not sputum examination.

The high cost RNTP-DOTS approach advocated on the basis of minor experiences in Western cities can sink the country into severe international debt. It is based on the false assumption that the average Indian patient cares little about his/her own health or that of his/her family and children to whom the disease may spread. Hence a 'responsible' person must be paid to see the patient swallow the required capsules under direct supervision of the employee of an external agency. This remarkably naive belief is propagated by those who have no knowledge of the Indian reality and the reasons why a centralised 'free' tuberculosis programme fails to reach the poor. Such a programme foisted by foreign 'experts' fails to understand the difference between education, intelligence and self-interest, and the difficulties to ensure regular and prolonged treatment under the existing conditions, many of which are not of the patient's making. This has been demonstrated by a most detailed combined medical and sociological study on this subject (Uplekar et al 1999).

There can be no better person for early suspicion of tuberculosis among her neighbourhood than the CHF who knows the index case and those who live in the same house or neighbourhood. She is knowledgeable about the cardinal symptoms of this disease and can collect the sputum samples for microscopy at the SRU or Taluka/Block hospital. After confirmation of diagnosis she can ensure regularity of the prescribed treatment. Both the CHF, the patient and the community have a strong interest in cure and preventing the spread of the disease in their locality. The Taluka Center can assure regular supplies of the drug, examination of sputum and x-ray when necessary. The Sahyogini and supporting doctor are available to help when there is any complication of the disease or drug.

Non-communicable diseases

Acute respiratory infections (ARI) - ARI is a common problem especially in the cold season. Though it affects all ages, it is the commonest cause of infant and child death especially among the undernourished poor, Drs. Abhay and Rani Bang in the tribal district of Gadchiroli have demonstrated how illiterate tribal women can undertake early detection and prevent the majority of these deaths by training mothers in the simple observation of increased rate of respiration and signs of respiratory distress followed by treatment with a simple and cheap drug such as cotrimexazole. This also demonstrates of the feasibility of the control of such a major national disease problem by the community itself. (Bang et al, 1993).

Cardio-Vascular diseases - The estimated incidence of rheumatic heart diseases is approximately 6 to 7 per 1000 amongst school going children. Obviously actual incidence in a community will be higher considering not all children go to school. Coronary artery disease incidence is on the increase in the rural areas but is nowhere as high as in urban areas (Personal communication Dr. Ratna Magotra, professor and head of the department of cardiovascular surgery, KEM Hospital, Mumbai, 1999). This is the result of differences in lifestyle, diet, exercise, mental tension and pollution.

Any problem can attain large numbers in a population of a billion and hence requires a more critical evaluation for concern and funding than mere numbers as is often used by specialists with their own narrow technological and monetory interests which are generally influenced by their Western training and outlook. Political and professional clout cannot be permitted to determine the policies of Health for All, in a democracy.

Despite external pressures the vast majority of our people are not alienated from their age old culture, practices values, traditions and beliefs. They accept the normal process of aging with grace, and death as the inevitable consequence of birth. An entirely different approach from that of the West or

of our Westernized elite.

Under the circumstances, it is preferable to pay attention to Rheumatic Fever which when neglected is the cause of valvular heart disease, especially of the poor. The diagnosis is simple consisting of sore throat and joint pain in children. Prevention consists in the provision of a simple and safe antibiotic like penicillin. This cardio-vascular disease unlike many others hence lends itself admirably to the attention of the Community Health Care System. Suspicion, confirmation and preventive treatment can be most effectively carried out at the CHF supported by the VHF and SRU. Mitral stenosis is the common manifestation of heart disease in a large number of patients as a result of untreated rheumatic heart fever. In its uncomplicated form, most of these can be treated with a simple and safe operation like transthoracic digital commissurotomy. This simple operation is effective and economical at approximate cost of Rs.2,500 as compared to technically advanced "percutaneous balloon mitral valvuloplasty" at a cost of over Rs.75,000. (Personal communication Dr. R. Magotra, 1999). This is a classical example of the dilemma posed by succumbing to ad hoc imported cultural and market forces in relentless search for profit which thrive on unnecessary technological sophistication regardless of the reality or the needs of the majority of our people. Such technologies divert our limited resources and attention from Health for All to Wealth and Health for a Few.

Medicine, surgery and preventive health as practised by the West in the early half of this century carried many of the ingredients appropriate for the health and medical care of our people today; more so if used in conjunction with our own as well etablished as also all other available systems of medicine and health care.

The medical professional, especially the specialist, is often not the most appropriate person to decide on Community Health and Medical Care for this requires a more mature and broader understanding of social reality, sociology, epidemiology, politics, bureaucracy and economics, which have little place in the existing narrow technology-based medical and nursing curriculum.

Family welfare

Population control has dominated the health scene since the inception of the National Family Planning Programme in 1952. Though it has far greater social, economic, cultural and political dimensions, the burden has been placed almost entirely on the Public Health Services for another techno-managerial solution for what is primarily a social problem. A separate section of the Ministry for Family Planning was instituted, later euphemistically termed as Family Welfare. An intensely human problem has been converted into another 'target' oriented bureaucratic, techno-managerial and medicalized exercise utilizing a never ending series of contraceptive technologies addressed chiefly at the eligible female in her child-bearing period. Yet this coercive policy against the helpless and helpless female has failed to achieve its desired result except in Kerala where the targets have been exceeded even without coercion due to education of the female. The mother in Kerala now has to be dissuaded from undergoing tubectomy immediately after birth of two children and use non-terminal methods till the children are above the age of 5 years for ensuing safety. This reveals the need for an entirely different approach which would make the female herself seek help for the technology of her need and her choice at a time, place and in a manner most suitable to her personal and family requirements. The annual nine million abortions, nine tenths of which are conducted illegally, demonstrates the demand which fails to be met by the Family Welfare programme.

What is even worse is that this harsh and dehumanized 'target' oriented approach for population control has alienated the people

from the entire health services which fails to provide their curative felt needs in an easily accessible and humane manner. Despite coercive targets and more recent 'targetless' pressures, it has failed to achieve its goal. The difference between such 'target' achievements and census figures demonstrates the extent of falsification of data generated under pressure.

The Community Health Care System offers a unique opportunity to achieve real Family Welfare together with its associated population control to the extent that it is feasible and desired by the people in a democracy. Such an approach would establish the intimate relationship between the women and their own CHF who is a part of the extended family in her local community. Someone who without transfers and 'targets' pressures seeks to provide a comprehensive health and medical care to those who are her own friends and neighbours while maintaining confidentiality and ensuring ante-natal and post-natal care; which is as much a social as a technical function. She also ensures the supportive services of the entire system including curative services which is accountable to the community. Only such a humane, highly personalized and caring system, accessible at all times, provides the necessary milieu for seeking advice and help for problems concerning the most intimate decisions not only of the woman but also of her family.

The Community Health Care System hence provides ideal conditions for achieving Family Welfare where Maternal and Child Health, RCH and Immunization are not mere adjuncts to persuade women to submit to sterilization or other contraceptive technologies to achieve national targets. Limiting child birth is only an ancilliary to the overall care and empowerment of women.

Acting more as a friend, the CHF is the most effective person to guide women seeking temporary or permanent measures of contraception. She will ensure immunization and care of the children who are born, guide the woman on reproductive problems and accompany her at deliveries and operations. The VHF can provide additional knowledge and help and undertake uncomplicated deliveries within the village. Ante and post-natal care are as much social as technical functions at the level of 50 households.

The Sahyoginis can ensure good technical ante-natal care eg. Haemoglobin estimation, urine for sugar and albumin check for pregnancy and any warning signs, register the primipara for delivery at the SRU and have the expectant mother checked up for possible complications at the People's Hospital and have her admitted if necessary. She can undertake episiotomies and even low forceps. With good communication and transport at her disposal she can have access to the Hospital for emergencies like blood transfusion for post partum haemorrhage and Caesarean section at any time of the day or night.

The services of the People's Hospital is available at all times for such emergencies as well as routine operations like mini lap tubectomy.

Mental illness and physical disabilities

These can be no better elucidation of these problems than provided by Dr. R.L. Kapur who is an authority on community mental health. Hence the following is as quoted by him.

"The decentralized Community Health Care System offers a remarkably simple humane and cost effective means for the care of these problems which affect almost 10% of the population in various degrees of seventy due to congenital defects, birth trauma, diseases like polio and leprosy or accidents. With a little education to the CHF and through them the community, the majority of these disabilities can be more humanely treated and cared for within the community itself rather than segregated in large impersonal institutions which are difficult to operate even at great cost. Such institutional treatment should be

reserved for the few intractable cases.

Mental illness - Involving the community and family members in the treatment of the mentally ill has a number of advantages. Firstly, it reduces the hostility in the minds of the patients, associated with having been rudely abandoned in a strange place. Secondly, when the family starts seeing the patients getting better, it helps to remove age old myths about the incurability of mental illness. Finally, by taking part in group sessions, the relatives learn the essential principles of mental health which help them to improve their own quality of life as well of their family.

Along with eliminating the difficulty of taking patients to distant hospitals, the cost of travel and so on, the most important contribution is to bring about a greater involvement of community leaders and neighbours in the therapeutic process and reduction of the stigma attached to mental illness. With some family members taking the lead in getting their sick member(s) treated openly, it was easier for other families to follow suit.

This also helps in the demystification of the phenomenon of mental illness. It was made obvious that an M.B.B.S. doctor and a village health worker could do equally well after a short period of training, what previously only a highly trained specialist was expected to accomplish.

Epidemiologists claim that while the rate of psychosis is one to two per cent, that of neurosis is eight to ten per cent. If we were to include in this category, conditions like substance abuse and personality disorders of various kinds, the percentage will go up even higher. It is also true that at least one-third of the patients who go to doctors suffer from psychological distress rather than physical illness. However, it must be remembered that these conditions are not diseases in the usual sense of the term but an expression of one's inability to cope with the hardships of life. Most of these require psychotherapy and social intervention rather than medicines. Unfortunately, there has been an increasing medicalisation of distress. An average doctor does not have the time nor the basic skills to address to the basic stress which made the patient seek help in the first place. As a result, he finds it more convenient to give tranquilizers. Tranquilizers do work but only temporarily. If used for long without simultaneously helping the patient develop sensible coping strategies, these lead to dependency and drug abuse.

In favour of community efforts to promote mental health, it must be stated that promotion of mental health is too important a matter to be left to the mental health professionals alone. There was a time when the society offered different kinds of support measures for the mentally distressed: the family elders, village mantarwadis, temples and so on. Stories from folklore and mythology were used to rouse a person to a meaningful existence in face of the vicissitudes of life. There were clear cut values to live by. Today, social change has diluted these values and the stories which were effective once, appear to be puerile and irrelevant to the modern sufferer. The situation is much worse in urban slums where the sense of alienation is even greater and social support even less.

Taking mental health care to rural primary health centres will affect and perhaps disrupt traditional socio-cultural support systems. This refers to the vast infrastructure of traditional healers who exist in our country. We have at least one traditional healer for every 500 people and we might end up marginalising these people who are not only healers and providing psychiatric and medical help but also are the repository of our cultural heritage in many ways. Whether we like it or not, the PHC system of our country, even in rural areas. is essentially a western system. This will disrupt not only traditional healing but also many of the traditional values which exist in our culture.

What we need urgently is an effective community education programme to fight the excessive use of these drugs. One must also focus on the drug company-practitioner axis and counter the pressure (including bribes) that companies employ to prescribe these medicines. There is also research evidence that consistent parenting and a schooling which provides meaningful challenges without oppressing the child, can in fact prevent occurrence of mental disorder in later years." (Kapur, 1995)

Hospital care

The exponential increase in the expenses of hospital care in the past two decades does not represent the real cost of such care but is the result of the worldwide operation of market forces where the ultimate charge has little relation to actual cost of service but is determined by what the client can afford to pay. The five-star private hospital seek to provide a facade of elegance and sophistication to attract its affluent clientele and often subjects its patients to the 'latest' expensive technology imported from the West for investigations and treatment without awaiting the long term evaluation of its safety or cost-effectiveness. Serving a Westernized clientele who generally confuse cost with effectiveness, this helps in the promotion of glamour technology rather than the well established and better evaluated, safer and cheaper alternative/s. The following are a few examples provided by the authors based on the experience of their work in government teaching institutions in five-star private hospital and also in rural hospitals. The following are a few of the examples that illustrate the differences.

Accidents and emergencies - Most accidents and emergencies are household incidents varying from minor cuts and bruises in children to major burns. Agricultural injuries from farming equipment, transport or animal injury are other causes. Bites from snakes, scorpions, insects and animals are also common problems in the villages. Deliberate or accidental pesticide poisoning is now common.

The village health functionaries can attend to most minor injuries by simple cleansing and applications, bandaging or splinting. The Sahayogini at the SRU can undertake cleaning and suture of superficial wounds. They are trained to suspect if not diagnose more severe problems like internal injuries while, the VHF and SRU can provide first aid, resuscitation and seek advice and help. If needed she can call a jeep or ambulance with a doctor or nurse and accompany the patient to the taluka hospital.

Burns - It is the most severe injury sustained by the human. Treated with simple soap and water treatment in his own specialized air-conditioned Burns Unit of a medical college hospital, in a rural hospital and in a five-star private institution, the results showed little difference while the cost increased ten fold at each level as also contractures. Air conditioning in fact proved counter productive.

Immunization - It is well-known that a number of deaths and disabilities can be averted by vaccines. The selection of vaccines must be based on cost, ease of utilization and effectiveness. Unfortunately the delivery of available vaccines, especially those requiring a cold chain, leaves much to be desired despite expensive vertical time bound programmes like EPI operated through the public sector. The private sector fails to reach the poor who are most in need of such vaccines despite the fanfare of the 'camp' approach. It also greatly increases the cost of delivery to those who are willing to pay. Vaccination, especially of children, must be an ongoing and sustainable programme not undertaken as sporadic campaigns. The Panchayat system with health functionaries in every village can ensure bulk purchase and distribution of vaccines. This offers a far superior method for immunization of the population as an ongoing activity without the need for separate time limited

vertical programmes like EPI (Extended Programme for Immunization), while children continue to be born after the pressure of the expensive 'delivery' programme terminates.

Projects like Mandwa have demonstrated that village health workers trained in simple sterile technique using non-disposable glass syringes and non disposable needles can ensure effectively immunization of the entire community with safety, on an ongoing basis at little additional cost than of the vaccines (FRCH, 1981). Nevertheless it must be emphasized that the real cause of these vaccine preventable diseases is poverty and what is really required is a vaccine against poverty! This lies in the realm of politics rather than mere medical action. This also lies in the people's own effort and action. The increasing vaccine related approach to solve the problems of the communicable diseases originating in poverty is a typical Western techno-managerial 'fix' for what is a problem of poverty which lies in the realm of political action by the people themselves.

Head injuries - The commonest aspect of neurosurgery is in the treatment of acute head injuries. Good clinical examination including level of consciousness and eye signs can provide adequate information to decide on the need for surgery. The difference between this and a CT or MRI scan is not only the cost but the danger of delay in immediate intervention. Whether one or four trephine holes are necessary is of little consequence and can be undertaken by a general surgeon in a rural hospital.

One of the authors oration provides information as to how effective surgical care can be provided in rural hospitals in a remarkably cost-effective manner by general surgeons without unnecessary sophistication which is the result of over-specialization. Cost and effectiveness have little relation in medical care leave aside that of health. As a rule good health and medical care is remarkably cheap while unnecessarily expensive care can not only be overtly expensive but can even be dangerous. Unfortunately the health industry operates on an entirely opposite principle in an area where consumer resistance is at its lowest.

The effect of concern, empathy and the placebo still dominates the art of healing as used by the vaidyas, doctors or nurses has been grossly underestimated. Unfortunately this inexpensive but powerful tool in the medical armamentarium has little place in the Descartian bio-medical understanding of life. There is no better functionary than the CHF, VHF and Sahyogini for reestablishing this intimate role with the support of a well staffed and well equipped People's Hospital, Health and Training. A system which eliminates the distorting profit motive.

For details of some Common Medical Problems and their Referrals in the Community Health Care System, see Annexure 2.

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11

Medical Education

As stated previously the community with its specifically trained workers can also undertake many other medical problems if taught and also use much of the available knowledge and technology if encouraged and provided the necessary supportive services.

The problem of maldistribution of Physicians by Geography and speciality is a consequence of such factors as emphasizing learning sub specialists.One educator noted that "Doctors find themselves unaccustomed to assess and evaluate the health care needs and priorities of their own country and its people. They are incapable of providing or implementing preventive programmes. They are unprepared to work in the slums of the cities or to manage a rural health care team" (Bollong, et al 1982)

WHO and UNICEF organised a world conference on medical education in Edinburgh in 1988. The subsequently published 'Edinburgh Declaration' stated that "the present system of medical education is information imparting and not problem resolving. It is not community oriented and not integrated with the basic sciences from the beginning". The General Medical Council (GMC) of Great Britain made a review of medical education in its own country. The World Medical Association organised a conference on Medical Education in California in 1989. All these conferences have pointed out the inadequacies of the present form of medical education.

Medical Education is facing global criticism for two main reasons. It lacks reference to the tasks which are to be performed at the primary health care level and results in maldistribution of its graduates by geography as well as speciality. The explosion of scientific information also makes irrelevant traditional curricula which are based solely on existing knowledge. Educational reform is hence a crying need.

The process of evaluation of health care and medical education started in India in the pre-independence period. The Sokhey Committee (1948) and the Bhore committee (1946) dealt with the problem of medical education including its community orientation. The following three decades saw a few concerted attempts towards this end. The Shrivastava Committee (1975) diagnosed the majorproblems and outlined the challenges. The major problems that were pointed out in the report included the strong desire of the medical educators towards the old inherited teaching methods, with almost exclusive orientation to hospital-based tertiary care and not to the health needs of the community. The increasing trend towards specialisation and acquisition of postgraduate degrees was partly due to the attraction of the export market for our medical manpower.

Numerous documents have been produced for the re-orientation of medical education by various organisations including the Medical Council of India. The Planning

Commission, Government of India, State Medical Council of India in their policy statements through The National Medical Education Policy of 1986 attempted to formulate the curriculum for under-graduate medical education in 1993.

Despite the institution of a number of committees and their useful recommendations, no tangible change has been implemented in the medical education of our country to date.

Why is Change Needed

The objective of medical education is primarily to support the development of the health of our nation, and hence it should be community-oriented. Unfortunately our Medical Education is primarily hospital-based, specialisation-oriented and dependent on sophisticated investigative procedures. The curriculum is overcrowded with factual information which inhibits the student from developing creative and critical thinking to solve problems. The Edinburgh Declaration states "the aim of medical education is to produce doctors who will promote the health of all people". It further states that "Scientific research continues to bring rich rewards, but man needs more than science alone, and it is the health needs of the human race as a whole and of the whole person that medical education must affirm." The Declaration suggested enlargement of the setting in which educational programmes are conducted to include all health resources of the community, not hospitals alone, and to ensure that the curriculum content reflects the national health priorities and availability of affordable resources. It also emphasises the shift of training from passive to active learning. It is unfortunate that our medical education does not follow the spirit of the Edinburgh Declaration.

What are the Obstacles?

The greatest resistance comes from the teachers themselves, both senior and junior, who do not want change. Teachers express concern that if community orientation gets priority, teachinghas to be programmed beyond the four walls of hospitals and the medical colleges. This would entail that the selection of students and teachers will have to be restructured and reorganised and creates fear that the standards of education will suffer. They have also a considerable vested social, political and personal financial interest to resist any reform of the present system.

The students are also initially resistant to such change. They are never taught to imbibe the spirit of questioning, relevance, innovation and social commitment in their pre-medical education. What they want is a degree and training which will enhance their commercial market value; not an education which will give them better scope to meaningfully serve the people.

The attitude of the Government authorities and the attitude of the prevailing political system is another factor opposing such change. Unless the Government and the political system agree to these innovations, neither the resources nor the will will be available to implement such reforms.

There is also the dilemma of medical colleges where excellence is defined in terms of sophisticated technology and specialization.

Specialization in public health is directed more towards a mechanical form of health management. Public health authorities are paying little attention to comprehensive public health measures which are distorted by a multitude of vertical programmes and projects.

There are several lacunae in the concept of health care the chief of which is the failure to understand the politics behind the present practice of health care, specially in the 'need-based' countries.

A persistent, strong and unbiased political will is required to overcome these obstacles and to reorient medical education

for better service to the community.

Medical education has to be :

- Community-oriented and need-based
- Problem-oriented and self-directed.
- Of an integrated nature from the very beginning.

To implement such a medical education policy changes are needed at the following levels:

- Better general education
- Better selection of medical students
- Improved curriculum and course of undergraduate medical education.
- Different types of post/graduate training for community service, for specialist service, as well as for medical teachers and researchers. The following points need to be considered.

Changes in General Education

- Change in school timings to accommodate the economically weaker section of our population. Evening and morning classes could replace the 10 am to 5 pm system.

- Free education for all upto pre-medical entrance.

- Orientation of the teachers.

Selection of Medical Students

- Selection should be based on school assessment with a preliminary written test to be followed by an oral aptitude test. A follow-up of the achievements of students in relation to their performance in the entrance examination should be made in subsequent years.

Course and Curriculum of Undergraduate Education should include

- A short premedical curriculum for exposure of students to liberal arts, social and political science and natural sciences eg. economics, statistics, use of library and continuous education including audio visual aids. Above all, the non-medical components that dominate health.

- An initial training in the rural set up together with an outline of basic sciences in an integrated manner with emphasis on the preventive aspects, knowledge about the living conditions of the local people, their food habits and sanitary disposal, morbidity and mortality pattern, ecology of diseases etc. Also, understanding the reality of the 85% of the population that live in rural India and in urban slums.

- Followed by training in regional centres providing greater variety of problems, integrated clinical acumen along with pre and para clinical training by specialists of different disciplines, together with continuous assessment.

- Final training in medical colleges in the basics underlying tertiary and quarternery care.

Curriculum development must be dependent on

- Need of the community and the objective of creation of basic doctors.

- Integration of preclinical, paraclinical and clinical courses.

- To induce self-directed learning.

- Developing the problem-solving capacity of the students

The present system of medical education is specialist oriented. Institutional teaching isolates the medical students from the community by keeping them in a captivated environment. There is little scope for interaction with the community. The patients in the medical college hospital become 'cases'

and numbers. There is lack of a human touch so necessary in caring and the attempt is merely to cure diseases.

An experimental approach is necessary to reorient medical education, so as to be relevant to the health need of the Community. This has been implemented by various countries and universities such as the National Autonomous University of Mexico, Michigan State University, Thailand University, University of New Mexico, USA. Rush Medical School, USA, Shanghai Second Medical University, China, under the aegis of WHO, (New track). The Certificate Course for Distance Education of rural surgeons is an innovation of the Indira Gandhi National Open University of our own country.

The Program de medicine General Integral (PMGI) model of National Autonomous University of Mexico is worth consideration. 'There the students learn the rudiments of early diagnosis and prevention through contact with health centre clinic patients and by home visits and survey with the population at large. "Students participate in an ongoing study of their community.

This gives the students a basic understanding of the theory and practical reality of social, economic and medical problems.

General Duty Officer in The Community Health Care System

Though a doctor from any stream can be appointed as a General Duty Officer (GDO), he will require all-round training. He will be a general purpose social and managerial physician whose function will be to look after most medical and even simple surgical problems.

Functions - Able to give anaesthesia for most cases

- Use basic instrument
- Interpret X-rays and Sonography
- Assist surgeons in the operation theater
- Sound grounding in Preventive and Social Medicine
- Communication skills for training and contact with patients, relatives and community and its leaders.
- The Medical and Nursing Council will have to reorient their approach to produce such personnel to serve the major needs of our society.
- GDOs should also be from other systems like Ayurved and Homoeopathy.

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12

Communication and Transport

A major problem in the rural areas as compared to the urban situation is the widespread distribution of the population and the long distance and difficult terrain that has to be covered with a paucity of transport and lack of communication. Even when available the regularity of transport and maintenance of telephonic or other communication leaves much to be desired. This affects not only the transport of patients, especially in an emergency, but also the time spent in the distance to be covered by the health personnel as also their safety. It also affects the effective functioning of services at all levels from the village and its sub-centers, the PHC and the CHC (Rural Hospital). Adequate communication and transport can not only improve the service but can provide confidence to the staff as well as the community. It also affects the routine functioning as well as training and referral services even in normal, leave aside hilly terrain. This is one of the reasons why doctors and nurses of the PHC seldom visit the subcenter, villages, and 'targets' are achieved by the 'camp' approach rather than as a routine function. Lack of communication and transport is a major handicap in rural health and medical care.

Although a jeep is provided to the PHC, the limited petrol allowance, lack of maintenance and irregularity of the driver limits its use. The supervision and support of work at the subcenter and in the villages which was to be a weekly function is hardly ever performed. The contact of the PHC with the outlying paramedics is chiefly at monthly meetings held at the PHC. This too is basically of an administrative nature and does not permit the functioning of the PHC as a team even for motivated staff. The jeep is chiefly used for Family Planning operations during 'camps' or when there is an epidemic and for the monthly visit of the doctor to the District Health Officers meeting. It is often commandeered by the local leaders especially during elections.

The experience of various voluntary organizations and other institutions undertaking similar rural programmes reveals that 10 to 15% of the cost of the project is essential for transport and communications for ensuring an effective programme. This is also true of the Community Health Care System. Decentralization and using local functionaries can to an extent reduce the need for communication and transport but not replace the need for such services. The effective service offered by the PHC without adequate transport is restricted to a radius of about 5 to 10 kilometers. The CHC chiefly serves the taluka town and its immediate surroundings in which it is situated. This has reduced not only the effectiveness but also the credibility of the existing public health service.

An important advantage of the decentralized Community Health Care System is that the majority of the staff are local residents and are available at the village or SRU anytime of the day or night without need of transport. This also applies to monitoring,

support or supervision. Adequate transport is essential at the People's hospital and Health Complex for training and transport of patients, especially in emergencies. Also for the important weekly Reverse Referral aspect of this System, transport plays an important role.

Repairs, maintenance, availability of fuel and of drivers is much easier at the taluka level than at the present village-based PHC. Needless to say wherever public transport is available this must be utilized to the extent possible in preference to the more expensive jeep. Motorcycles and cycles can be used as cheaper vehicles for transport of staff whenever possible.

In addition to transport other means of communication like the telephone or even better, the newer means of telecommunication can provide 'expert' advice especially in emergencies. It increases the confidence of the community and its health workers in the entire system. Telecommunication technology needs careful study and experimentation because it has considerable potential in such a decentralized health care model if employed appropriately. It can also be used for training of personnel, administration and organization of the service besides serving, other non-health purposes.

The use of computers with appropriate software such as SYMPMED (Uplekar et al, 1988)) in association with telecommunication has the potentiality of revolutionizing rural health and medical care.

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13

Role of the Panchayat in the Community Health Care System

The importance of the participation of people in problems concerning their health and medical care was dramatically demonstrated in the first two decades after Independence as revealed in Chapter 2. Unfortunately this could not be subsequently sustained despite India adopting a representative form of democratic governance. In most countries and especially in a poor country emerging from centuries of colonial rule this has invariably resulted in a new centralised form of governance dominated by a few at the cost of marginalization of the interest of the majority.

Realizing this the founder fathers of our nation under the guidance of Gandhiji ensured universal adult franchise even with a then existing literacy rate of less than 12.5% and with 90% living in rural India (GOI, 1946). Forty six years later the disillusioned but politically awakened masses, have as a result of the pressure of their vote, been able to usher the true democracy of the participatory type through the 73rd and 74th Constitutional Amendments as visualized by the founder father of our nation. A form of governance most suited to the 85% of our population that still lives in 7 lakh villages and urban slums which is in keeping with our age old tradition of Gram Swaraj; a face to face relationship at the village level where every person is enabled to ensure his/her rights as a citizen of the country.

Together with the 29 subjects under Schedule 11 this opens up a new dimension to the development of our country from a top-down large scale urban industrial to a bottom-up small scale, egalitarian agro-industrial form of development based on our traditional civilization and culture. Though 'health' is one of the subjects allocated to the Panchayats it has to be realized that improvement in health in its wider context will be achieved more through improvements in other subjects like education and nutrition rather than in the narrow context of medical care with which health is generally understood. And yet despite much mystification even the preventive, promotive as well as curative aspects of medical care can be most effectively undertaken within the Panchayat levels as indicated in this report and that too in a far more humane, accessible and cost-effective manner. In the process it also provides large scale employment to its functionaries especially women within the village itself. Demystifying medicine would also give confidence to the Panchayats in the other not so mystified subjects.

Though election may be a part of Panchayati Raj the face to face relationship ensures better control over their elected leaders thus reducing corruption and nepotism. At the traditional Gram Sabha level it is consensus and cooperation rather than divisive party politics as practised at the State and Central levels. The poor and disadvantaged hence receive better attention at this level.

The effective functioning of Panchayati Raj cannot be achieved merely through a

According to the latest WHO estimates (1999-2000), India's total expenditure on health and family welfare is 5.6% (public expenditure 1.2% and private expenditure 4.4.%). For the purpose of comparison with our alternative model, we have taken the lower figure of 3.5% of GDP, which is certainly an underestimate.

Private sector expenditure refers to the expenditure of private individuals and households whereas public expenditure refers to the combined expenditure of the State, Central Government and municipal corporations. The expenditure of NGOs and the corporate sector have been ignored as even taken together it is not significant. The private sector expenditure of Rs.51,631 crores accounts for nearly 77% of the total health expenditure.

Of the Rs.15,520 crores annual expenditure in the public sector, two-thirds is expended in the urban areas where 30% of the population lives while one-third is expended in the rual areas which accounts for 70% of the population.(Table 2). Even in the urban situation, health expenditure chiefly supports unnecessarily sophisticated curative services such as large tertiary care institutions, medical colleges and research institutions and their overgrown administration as can be seen from Table 2. In the rural areas public expenditure in health is chiefly operated through the Primary Health Care approach of the Bhore Committee with the Primary Health Centre as its nodal point supported by subcentres and the CHC hospital. The deficiencies and lacunae of this system have been explained in chapter 2.

The private sector thrives mainly in urban areas, now overflowing to the more affluent fringe of rural areas. The high cost of the private sector is indicated by the household expenditure incurred on seeking curative medical care.

Table 2
Health Expenditure : Rural, Urban and by Purpose : 1991

(Percent)

	Rural	**Urban**	**Total**
Share of population	70	30	100
Share of expenditure	33	67	100
By Purpose			
Curative	37.8	71.3	60.3
Preventive	32.5	23.3	26.3
Others	29.7	5.4	13.4
Total	100.0	100.0	100.0

Source

Reddy, K.N. and Selvaraju V. **'Health Care Expenditure by the Government of India. 1974-1991.** Seven Hills Publications. New Delhi, 1994.

The corporate sector is as yet small as compared to the public and private sectors. It is also mainly curative oriented and serves the 'health' of the industry which supports it.

Except for the voluntary sector none of the other sectors have a social base in the community they serve. The public sector is inefficient as well as unaccountable to the people while the private sector is almost entirely curative oriented and increasingly exploitative in a market-based economy. It

thrives to a great extent on the inefficiency of the public sector. It has virtually no preventive or promotive content.

While all these sectors have their own self-interest and motives, the people also have interest in their own health as well as medical care which they seek at the lowest cost in keeping with effectiveness. The popular myth of equating good health with doctors, hospitals, injections and other expensive Westernized medical care engendered by the medico-industrial complex needs to be questioned and demystified.

If with the use of the most cost-effective aspect of allopathy, the people's role in self-care together with utilizing the best aspects of all modes and systems of health and medical care is encouraged and demonstrated, people should have little difficulty in accepting a more humane and cost-effective method for improving their personal and community's health.

While the previous chapters have demonstrated the technical and social advantages of the suggested Community Health Care System, this chapter attempts to demonstrate the economic viability as well as sustainability of this system at all levels. Without depending on the public or private sectors this people based and people operated system can provide a far more cost-effective health and medical care to all, including the poorest, at less than one-third of what is presently expended in the combined public and private sectors.

The present public sector expenditure on rural 'health' is chiefly through the Primary Health Care system consisting of the CHCs, PHCs, SCs and village CHWs now designated as Health Guides. This is borne jointly by the State and the Central Ministries of Health and Family Welfare. The Ministry of Health operates the CHCs which provide curative services while the PHC's main function is to achieve the 'targets' of a variety of vertical disease control programmes. The Ministry of Family Welfare supports the Subcentre and Village Health Workers (Health Guides) chiefly for population control with its ancillary programmes like Immunization, Maternal and Child Health, Child Survival and RCH.

Almost 85% to 90% of the cost of operating the present rural health service (especially after the implementation of the Fifth Pay Commission's recommendation) is on salaries, leaving hardly 10 to 15% for all other expenses like medicines, supplies, administration, maintenance, communications and transport. This has resulted in further loss of credibility of the entire public health service even among the poorest sections of our society who either suffer in silence or incur heavy expenditure or even incur extensive debt to meet the cost of private health care which treats them with some respect, even if only as clients for profit.

This distortion of the public health budget by the salary component is a result of the pressure exerted by the small but powerful organised sector of the employees. Their interminable demand for more pay for less work has little concern for the remaining 90% of society which consists of the country's major work force which is in the unorganized sector. A political system seeking their vote is easily held to ransom by such organized segments of our society including those in the public health sector.

The salary paid to this organized cadre is totally out of proportion to that paid to much larger numbers in the unorganized or informal sector, especially those undertaking equivalent work in the rural setting. Despite the disproportionate salary, this sector which is subject to 'targets' and 'transfers' has no roots within the community and consequently no accountability to those who they are paid to serve.

Since Panchayati Raj is a self-governing institution employing local personnel who have

both social as well as financial accountability to their own people it provides the means for overcoming the inherent problems of such an invidious system. All this can be achieved at a cost equivalent to local scales provided by the community to any other individual undertaking similar work. Local social pressures would prevent unionization while ensuring better social as well as technical accountability.

The alternative

The Community Health Care system suggested aims at correcting the urban-rural, curative-preventive bias as well as the gross financial disproportion between salaries and other expenses. The social, technical and managerial aspects of the alternative model have been discussed earlier in detail. In this chapter we shall focus on the financial aspects at each level i.e. the village, the SRU and the Block/Taluka (People's Health and Hospital Complex).

The cost-effectiveness of the Community Health Care System is visualised as follows.

- Employment of local personnel at every level to the extent that is feasible, and training them within this system. This reduces the cost of salaries, training, travel and housing since all such staff are recruited and function within their own locality and community.

- Local rental accommodation is used wherever necessary to reduce cost as well as ensuring that the service is closely integrated within the community. It also permits high visibility, ready accessibility, support as well as monitoring by, and accountability to the people.

- Openness of all functions and transactions together with regular support and monitoring by the local community and its health committee avoids losses due to corruption and nepotism.

- All salaries and wages are in keeping with the local remuneration of similar workers in the same community and also accountable to them; this includes termination of services if necessary. Medicine at this level is demystified to a normal social and technical function as in all other fields.

- Continuous training ensures continuity of work even when new personnel are recruited. Hence the system cannot be held to ransom.

- Adequate staff is provided within this system for both training as well as transport and communications for emergencies as also for the weekly Reverse Referral Service.

- Mobilizing local community support such as shramdan at no extra cost for most functions e.g. preventive, promotive and curative with emphasis on the non-medical functions, rather than more expensive external functionaries like contractors as in the present service.

- Use of the more economical folk and indigenous systems of medicines and health care, in which preventive and promotive aspects of health care become part of the lifestyle and culture of our people.

- Emphasis on education, prevention, early detection and regular and appropriate treatment can greatly reduce the cost of curative services.

- Reduced cost of transport incurred by the people by utilizing the Reverse Referral service.

- Bulk purchase of drugs and supplies under generic names at the taluka level and its proper accounting distribution and monitoring.

- All buildings are constructed in local style by local workers, not using contractors. This reduces corrupt practices, reduces cost. ensures better workmanship, easier, cheaper and regular maintenance with local materials and labour. Existing structures like the CHC, PHC, SC etc. which belong to the Panchayats can be utilized in this system.

- Use of a dharmashala to extend hospital services at greatly reduced cost.

- Employment of local personnel enables the ratio of salaries to other expenses to be reduced from 85:15 to 60:40 for the hospital and, even 40:60 for the health and training components, ensuring adequate availability for drugs, supplies, maintenance, repairs etc.

- All personnel are utilized in a multi-purpose and not unipurpose manner as far as is feasible.

- All personnel selected would be those who are in broad sympathy with the terms and objectives of `Health for All'.

- Emphasis on the Health component i.e prevention and early detection which reduces the more expensive curative service costs.

- The fee charged for services in such a system is devoid of the profit motive. However, it will be prudent to generate a small surplus for the organization as a whole which may be then utilized with the consent of all concerned.

- Financial and administrative accountability and control is ensured at every level. Access will be provided to books of account. minutes of meetings, files and records. Financial results will be displayed publicly at periodic intervals. This would ensure transparency and openness.

- Decreased load and better utilization of district and tertiary level medical services. This would help in the reallocation of skewed health resources.

- Ensures reduction and better utilization of the private sector. This is also the most effective way of controlling the charges as well as the quality and quantity of the services of the private sector.

- It would also lead to a marked reduction in the household expenditure on health care which not only includes the cost of medical care but also takes into account the cost of transportation, food, loss of working hours or days as relatives often have to travel long distances with patients to avail of medical care.

- Avoidance of unnecessary investigations and medication especially in the private sector, thus preventing the poor from diverting scarce resources from food to medicines.

The total cost at the 100,000 population level hence amounts to Rs.175 per capita per annum. For a family of five, this would amount to about Rs. 73 per month per family. (Table 3)

Detailed cost workings have been given in Tables 3-A to 3-E. All figures quoted, especially of the salaries are broadly *indicative* and hence can vary substantially from region to region and from panchayat to panchayat and even from village to village. Excessive payment to staff should be avoided as this would lead to competition and various pressures of nepotism and casteism for appointing the wrong type of personnel merely for monetary benefit. The decision of remuneration must be left to the local employing panchayat e.g. Gram Sabha, Gram Panchayat at the village level and panchayat samiti and its Gram Sabha at the taluka/block level. The salaries of the relatively few doctors and nurses needed will be in keeping with the current market rates, in order to be able to attract and retain appropriately trained professionals. The medical staff will in addition be provided good working conditions which are at present lacking in the private sector in rural areas.

Though the cost per bed per day of the proposed CHCS 40 bed rural hospital is much higher than that of the other two described in the above table, it is our contention that because of the adequate provision (40% of all costs) for food, drugs, supplies, administration etc. a much superior health care will be provided and hence utilized. In the

case of the two hospitals of West Bengal, salary costs swallow up 90% of resources leaving about 10% for other costs.

Equitable allocation of resources between rural and urban areas

If 95% of the total public health care of rural areas can be undertaken within the Panchayat System which covers 75% of the population, there is no reason why 50% of the overall Public Health Budget (Center States) should not be provided for rural public health care while leaving 50% of the budget for 25% of the population which is urban. As per the present per capita public sector health expenditure of Rs.157 (Table 1) this would work out to Rs. 78.

With more humane, cheaper and superior health care without the profit motive, it is expected that at least half of the per capita expenditure incurred on the private sector of Rs.521 (i.e. Rs.261 per capita) can be diverted to the Peoples Sector. This would provide a total of Rs. 339 per capita, which is much in excess of the estimated expenditure of Rs.175 per capita required by the Peoples Sector (Table 3), while leaving Rs.164 per capita for capital expenditure for buildings, new equipment etc.

Since there are no PHCs in this proposed system all currently existing government buildings and facilities like the CHCs, PHCs and SCs as far as possible can be utilised for meeting the objectives of the proposed Community Health Care System, thereby reducing the capital cost. Cheaper local rental accommodation can also be used as and when required and available.

The Grama Sabha would identify the individual families in its area below the poverty level (roughly one third) once every 3 years. Such persons would be given health cards for an entirely free service or on payment of a token sum.

Table 3
'Indicative' cost structure of the community health care system for 1,00,000 population.

Levels	No. of units	Total staff (No)	Salary costs p.a. (Rs.lakh)	Drugs & supplies* p.a. (Rs.lakh)	Total cost p.a. (Rs.lakh)	Per capita cost p.a. (Rs.)
Village level	100	500	23.50	15.67	39.17	39.17
5000 pop level	20	80	19.00	12.67	31.67	31.67
People's Hospital	1	44	29.00	19.33	48.33**	48.33
People's Health complex	1	18	14.00	21.00	35.00	35.00
Sub-total		**642**	**85.50**	**68.67**	**154.17**	**154.17**
Transport & Communications				20.00	20.00	20.00
Total					**174.17**	**174.17**
Approximate annual cost					**175.00**	

Notes

* Includes food, consumables, rent, electricity, depreciation of equipment, repairs and maintenance, stationery and administration.

** Includes cost of proposed dharmashala Refer tables 3A - 3E for details

Table 3-A
Indicative cost of people's hospital of 40 beds serving 1,00,000 population

(Rs.)

Staff	Nos.	Monthly salary	Total Monthly	Annual
Physician	1	30,000	30,000	3,60,000
General Surgeons	2	30,000	60,000	7,20,000
Anaesthetist	1	15,000	15,000	1,80,000
G. Practitioners-Allopathic	3	10,000	30,000	3,60,000
-ISM&H	3	10,000	30,000	3,60,000
Nurses	3	6,000	18,000	2,16,000
Nursing Assistants(female)	15	2,000	30,000	3,60,000
Male Attendants	6	1,000	6,000	72,000
Technicians	3	2,500	7,500	90,000
Pharmacist	1	2,000	2,000	24,000
Drivers	2	1,500	3,000	36,000
Others	4	1,000	4,000	48,000
Total	44		2,35,500	28,26,000

Approximate salary costs	29,00,000
Cost of drugs, supplies etc. (Computation based on ratio of 60:40 between salaries and other daily expenses)	19,33,000
Total costs	48,33,000
Total per capita cost (for 1,00,000 population)	48.3

Table 3-B
Costing of people's health centre serving 1,00,000 population

(Rs.)

Staff	Nos.	Monthly salary	Total Monthly	Annual
Chief Health Officer	1	30,000	30,000	3,60,000
Senior Asst.	4	10,000	40,000	4,80,000
Junior Asst.	4	8,000	32,000	3,84,000
Administrative Staff	4	2,000	8,000	96,000
Drivers	2	1,500	3,000	36,000
Others	3	1,500	4,500	54,000
Total	18		1,17,500	14,10,000

Approximate salary costs	14,00,000
Cost of training and other health activities (computations based on 40:60 ratio between salaries and training and other activities)	21,00,000
Total cost	35,00,000

Table 3-C
Costing at the 5,000 population level (SRU)

(Rs.)

Staff	Nos.	Monthly salary	Total Monthly	Annual
Sahyogini	80	2000	1,60,000	19,20.000
Approximate salary costs				19.00.000
Cost of drugs, supplies etc. (computations based on 60:40 ratio between salaries and cost of drugs, supplies etc.)				12.67.000
Total cost				31,67.000

Table 3-D

Costing of village level services (average village population 1000)

(Rs.)

Staff	Nos.	Monthly salary	Total Monthly	Annual
CHF (part-time)	400	300	1,20,000	14,40.000
VHF (full-time)	100	750	75,000	9,00.000
Total	500		1,95,000	23,40,000
Salary costs				23.50.000
Costs of drugs, supplies etc. (Computation based on 60:40 ratio between salaries and cost of drugs, supplies etc.)				15.67.000
Total cost				39.17.000

The various levels of the community health care system can be implemented either in isolation or in conjunction with each other.

Table 3-E
Costs at various levels

Staff.	No.	Monthly salary	Monthly costs	Annual costs
1. Village level				
CHF (part time)	4	300	1,200	14,400
VHF (full time)	1	750	750	9,000
Total	5		1.950	23,400
Salary cost			1.950	23,400
Costs of drugs, supplies etc. (computation based on 60:40 ratio between salaries and cost of drugs supplies etc.)			1.300	15,600
Total cost			3.250	39,000
Total no. of such units for 1,00,000 population- 100 units				
2. 5,000 population level				
Sahayoginis	4	2000	8000	96,000
Salary cost			8.000	96.000
Costs of drugs, supplies etc. (computation based on 60:40 ratio between salaries and cost of drugs supplies etc.)			5.333	64,000
Total cost			13.333	1,60.000
Total no. of such units for 1,00,000 population - 20 units				

Table 3-F
Expenses of major recurring heads of expenditure of the proposed CHC system

(Rs. lakh)

Heads	Cost	% of Total Cost
Salaries	85.5	49
Drugs & supplies	68.7	39
Transport	20.0	12
Total	174.2	100

Given below is a cost comparison of different hospitals:

Table 4
Comparative estimates of annual cost of different hospitals

(Rs. lakh)

	S.G. hospital West Bengal	Rural hospital West Bengal	Proposed (CHCS) Rural hospital
No. of beds	100	30	40
Cost/bed/annum (Rs.)	92,000	1,01,000	1,21,000
A. Revenue Expenditure			
Salaries	82.5(89.4)	27.4(90.1)	29.0(60)
Recurring Expenditure	7.8(8.4)	2.4(7.9)	19.3* (40)
Total	90.3(97.8)	29.8(98.0)	
B. Capital Expenditure	2.0(2.2)	0.6(2.0)	
Total Expenditure	92.3(100.0)	30.4(100.0)	48.3(100.0)
Cost/Bed/Day (Rs)	**253**	**278**	**331**

(Costs per bed per day have been worked out on the basis of 100% utilization of all beds, 365 days a year for the sake of comparison. In practice utilization may be much lower).

Notes

* for both recurring expenditure and capital expenditure
Figures in parentheses indicate percentage of the total.

Source : State Planning Board. Government of West Bengal.

15

The Urban Situation

The Community Health Care System has been primarily devised for the 74% of our population that lives in 7 lakh villages. Despite industrialization India remains chiefly a rural society. An uncritical Western style urban industrial form of development has resulted in an unjustifiable increase of the urban population from a meagre 8% to 26% in 50 years.

Despite a vast increase in the country's wealth which is concentrated in urban enclaves, 50% of the urban population that provides both organized and unorganized labour for this form of development lives in unhealthy slums and suffers from the diseases of poverty like their rural counterpart. Aggregate urban statistics conceals the gross disparity between the inhabitants of the slums and of the affluent urban enclaves.

Despite the plethora of doctors and hospitals, most of the urban population has poor access to appropriate health and medical care. The curative services are concentrated in a few large hospitals in both public and private sectors, providing an unnecessarily sophisticated medical service rather than a basic decentralized form of health and medical care for the common problems that they face daily. This diverts a substantial part of the earnings of both the poor as well as of the lower middle class from their normal household needs to an inappropriate form of curative medicine. This is especially the case in the private sector which has proliferated in the form of dispensaries at the periphery of the slums. The uncontrolled growth of the urban population, as a result of migration from rural areas in search of livelihood has swamped all civic amenities for healthy living. The conditions of the urban poor are in some ways even worse than of their rural counterparts with pollution of air, water and food. This is concealed by the aggregation of statistics.

Under the 74th Constitutional Amendment and its 12th Schedule the urban population also now has the right to demand a decentralised form of health and medical care as under rural Panchayati Raj. While distance poses no problem, this advantage over the rural system is more than offset by a plethora of inappropriate medical services that thrive on the diseases of poverty. The mohallas and their committees can serve as the counterpart of rural villages and devise a similar Community Health Care System with their local health and paramedical workers supported by small Community Hospital and Health Services as in the Community Health Care System. The answer lies primarily in redressing the mode of development of both rural and urban areas to suit the requirements of the vast majority using all available methods and systems of health and medical care.

The wards of our municipalities are often the size of a district. Though close in physical distance they are as remote in practise as the Panchayat/Block for access to information and services. Like any public system they are a law unto themselves and have little accountability to the people they are paid to

serve. It is hence necessary to divide the urban area into populations of 100,000 and further to 5000, 1000 and 250 households as in the rural Panchayats. Served by mohalla committees operating like the gram sabhas they can be further subdivided into committees for every 50 households. The same system with Sahyoginis and referral to a local 40-bedded hospital would vastly improved urban health, employing local functionaries as a result of financial and administrative decentralization. This would reduce cost improve interpersonal relationship between doctors and patients and reduce the overload on expensive specialized hospitals who can have more time to deal with the complicated problems.

Such a system where people are in charge of both medical and health services of their own locality and employ their own staff would bring back accountability into the urban situation.

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16

The Interim Phase

The Community Health Care System is a new approach to Health and Medical care based on the ICSSR/ICMR concept of decentralized people-based and people-operated health service, utilizing the available human and financial resources over whom they have both financial and administrative control.

As stated in the ICSSR/ICMR report such a peoples health care system can only be operated under Panchayati People's Raj which is now constitutionally ordained. Since Panchayati Raj cannot become functional immediately all over the country, the implementation of the system will go hand-in-hand with the development of the Panchayat system. Wherever the spirit of Panchayati Raj takes root, at any level this new model can and should be promoted and helped in its implementation.

While it may take over a decade for Panchayati Raj to operate effectively on a countrywide scale, people have already started gaining confidence and are learning to take charge of their own lives and demand what are their rightful dues which they realize is denied them even under the symbol of representative democracy.

Various methods for implementing the broad strategies of the Community Health Care System model will have to evolve, depending on the local socio-economic, cultural, epidemiological and geographic conditions.

It may have to be modified due to regional variations. People will learn how cooperation and participation can help the welfare of the entire community through exchange of knowledge, discussion, trial and error as also through conflicts and their resolutions and not through the vote but by mutual consensus. People may thus react to this model in different ways, at different places and at different levels.

- While the Panchayats are evolving, other changes will also influence the political system. On the one hand there is the growing phenomenon of globalisation, liberalisation and privatization which is favourable to a small elite while and on the other are the demands by the people for smaller and separate states. Above all, the 73rd and the 74th amendments has helped create awareness among people of their rights. People also realize that the power of their vote lies in a decentralised and highly visible form of participatory rather than in a distant over-centralised representative form of democracy which is essential to bring about the changes necessary for their own welfare and therefore in their own interest.

- There is increasing disillusionment and loss of faith in the existing system of party politics. With Panchayati Raj being ordained, the time is opportune to usher change by the people in a form of governance in which they can participate far more closely and effectively.

- People are also realising the excesses of the present system in the field of medical care which is unduly mystified, dehumanized

and commercialized, with lack of accountability of the Public Sector and the uncontrolled profit motive of the Private Sector.

□ Increasingly people are relying on and are reverting to folk and traditional medicine. There is an attempt even among the elite to revive the indigenous systems of medicine. There is also a wider use of homoeopathy and use of various 'alternative' systems.

□ Awareness needs to be created as to why medical care is now becoming a major cause of indebtedness. The answer does not lie in the Public/Private Sector but to take control of their own health and medical care to the great extent it is possible at much lesser cost.

□ What is important is to create awareness among the people about 'health' in its wider perspective.the demystification of medicine, the strengthening of our own indigenous methods and systems of health and medical care and to integrate and use of the best of all available methods and systems. This would also help to build self-confidence amongst the people.

□ A strong public information system creating awareness among the people at large will help them question the gross disparities in health as in the other sectors. People will justifiably demand reallocation of resources for all 29 subjects, covered under Panchayati Raj, including that for health.

□ This would also lead to a change in medical, nursing and paramedical education. The over-production of doctors and nurses has led to saturation in the cities. Medical education will also have to be decentralized to the district level, be broad based, integrating the best of all systems and keeping with the requirements of the local community's needs. This will result in the decrease in the production of specialists since in the new Community Health Care System approach, over 95% of all health and medical problems will be undertaken within the taluka level.

□ All this will lead to the improved functioning of the People's Sector and consequent shift from the private as well as the public sectors. It would also be a more effective means for controlling the private sector than legal action.

□ This will also help the people and the Panchayat to rechannelise a substantial part of the wasteful expenditure in this sector into the people's own Community Health Care System which is under their own control.

□ Since a new cadre of personnel is required for this system, the existing staff existing have to be gradually phased out. While their salaries will continue to be paid by the Government this will now have to be routed through the Panchayats. This will ensure accountability to the people and not to a distant bureaucracy. The government shall freeze all further recruitment till the existing staff retires. An orientation training will help the existing staff to function more effectively for the requirements of the Panchayats.

□ With the provision of a good hospital environment and adequate salary in accordance with the prevailing market rate, there should be no difficulty in attracting medical and nursing profession to serve the relatively few but important curative function.

□ All functionaries in this system, apart from the few doctors and nurses, will be from the local village/s or taluka and will be paid the prevailing rate for similar functionaries/ workers in the same situation.

□ A new type of functionary will have to be developed for serving the non-medical as well as the preventive, promotive and curative needs of the community at an intermediary level between the village and the taluka which we term as a Sahyogini.

□ Accountability to the people will be inbuilt within such a people's own system and any attempt at unionization from outside will be opposed by the local community.

□ Shortcomings will be inherent in the early stages during the change over from an unaccountable top-down system to an accountable bottom-up system. This will have to be faced by the local community and its leadership at every level till the new system demonstrates its advantages.

□ Opposition will be inevitable from those who have a strong vested interest in the existing order consisting of the professionals, bureaucracy and the health industry employing the usual mystique and fear. Once initiated it should not be difficult for the people to be convinced of such a readily accessible, humane and highly cost-effective system.

□ For this, information about the principles, significance and functioning of this new approach to health and medical care, must be provided in the simple local languages to all citizens. Motivated professionals and these bodies can help in devising such information supported by the Ministry of Rural and Urban Development.

□ Besides providing theoretical model/s of alternative/s there must be practical grassroot demonstrations of the feasibility, as happened with the green revolution. Such widespread demonstrations in various parts of the country need not always be on a full scale Taluka/ Block level. Parts of this model can be undertaken independently eg. at the Gram Panchayat or Group Gram Panchayat level. Decentralisation of the health and medical system must be undertaken to the greatest extent feasible wherever the opportunity presents. This cannot be achieved on a countrywide scale without demonstrating the effectiveness of this decentralized model operated successfully by the people.

□ Till Panchayat Raj takes root, a number of experiments should be conducted not only with receptive Panchayats at various levels but also with voluntary agencies and other organisations and institutions from the village to the taluka level. Once the Panchayats are activated people will themselves implement this new model with suitable modifications for their local needs, utilizing the advice of their professional staff.

□ Demonstration of such a readily accessible, humane and highly cost effective alternative approach to health and medical care for **All Citizens** within and by the community itself will reduce dependency and the need for the existing public and private health sector. This will also make available extensive financial resources for other aspects of rural development eg. education, water sanitation and nutrition which support health and its care.

□ A plea may be made that in a vast country like ours nothing can be achieved except by a centralised public sector or through the Private Sector. The reverse is actually true. Piecemeal implementation of the ICSSR/ICMR model eg. CHC and CHW, by a centralised bureaucracy has inevitably failed for which this model and not the bureaucracy have been blamed. This should serve as a warning.

□ Good health and medical care is nowhere as expensive as the 'globalised' market tries to make us believe. This system is based on the operation of the 'small efficient people's market' and not on the requirements of the exploitative national or international market or a distant centralised and unionized bureaucracy, both with its own interest.

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Annexure - 1

Drug List

Internal Use

Home Remedies	Ayurvedic	Homeopathic	Allopathic
Ajwain	Haritaki	Aconite	B. Complex
Cinnamon	Jwar guti	Antimonium Tart	Calcium
Clove	Kankol	Arnica	Chloroquine
Garlic	Kuda parpatika	Biochemic 5 & 6	Co-trimoxazole
Ginger	Nag Keshar	Chameli	Domperindon
Isapghula Husk	Sanjivani Vati	China	Fersolate
Jaggry	Shankha Bhasma	Ipec	Folic acid
Murudsheng	Sutshekhar	Sulphur	Gelusil
Nutmeg	Triphala Churna		Gynaec-CVP
Salt			Ibrufen
Soda			Mebendazole
Sugar			Metronidazole
Turmeric			Oral contraceptives
Wood apple			Paracetamol
			Salbutamol
			Tetracycline
			Vitamin C

External Use

Home Remedies	Ayurvedic	Homeopathic	Allopathic
Aloe/Kumari	Karanj Tel	Arnica	Benzyl Benzoate
Dagadi Pala	Neem Tel	Calendula	Boroglycerine ear drops
Neem	Sarjeras Malham		Condoms
Nirgudi	Vranropan Tel		Diaphragm
Rui			Gentian violet
Turmeric			Hydrogen Peroxide
White Vinegar			I.U.D.
			Liquid paraffin
			Nystatin
			Potassium Permangnate
			Savlon
			Silver Nitrate drops 1%
			Suppositories
			Tetracyclin eye drops
			Whitfield ointment

Note : The above mentioned drugs can be prescribed by CHF, VHF. Sahyogini according to their own medical kit. (Medical kit attached in Annexure 2)

Annexure - 2

Some Common Medical Problems & Referrals

Acute Respiratory Tract - Infections

Community Health Functionary	Village Health Functionary	Sahyogini	People's Hospital
MEDICAL **Curative :** Suspects baby with breath counts more than normal, and severe cough and cold. Treats mild cases of pneumonia with Cotramexazole and steam inhelar. If breath count more than 50 per minute or after treating with Cotramexazol for 24 hrs or condition does not improve after 24 hrs, refers to VHF.	**MEDICAL** **Curative** Treats baby with Amoxicillin for breath count more than 60. Refers case if - * Baby is unable to cry * Baby is unable to suck milk * If condition does not improve even after her completion of antibiotics Refer to Peoples' Hospital	**MEDICAL** * O_2 therapy * Inj. Antibiotics * Intravenous/subcutaneous fluids	**MEDICAL** **Curative** Treats baby for severe Pneumonia
NON MEDICAL **Health Communication** - On the symptoms of Pneumonia and to seek help as early as possible.	**NON MEDICAL**	**NON MEDICAL** Preparation of papers, posters. Arranges to show available films/ video on dangers and treatment of pneumonia in infacts.	

Pulmonary Tuberculosis

Community Health Functionary	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Curative** Suspects TB if 1. Cough for more than 15 days 2. Low grade fever especially in night with sweating 3. Weight loss 4. Haemoptysis 5. Loss of appetite 6. Proximity to Index case Refer to sahyogini for confirmation. Ensuring Regular treatment for total duration. Suspect complication of disease or drug if patient does not improve during treatment and refers to Peoples' Hospital **Preventive and Promotive** Teaches home isolation techniques to patient and relatives. Nutritional advice and diet planning for patient **NON MEDICAL** **Health Communication** - Awareness on TB as communicable disease caused by bacteria and its symptoms to remove misconception and need for prolong treatment. **Organisation** - Organises community to support TB patients.	**MEDICAL** **Curative** Collection of sputum for AFB **Preventive and Promotive** Ensuring regular supply of drugs Record of all cases in a village and monitors them for progress. **NON MEDICAL** **Health Communication** - Communicates to ration shop owners to provide regular supplies to this patients. - Informs community about the linkages of TB to poverty **Organisation** - Organises community to provide light work to the patient in the field.	**MEDICAL** **Curative** 1. AFB examination and refers positive cases for treatment/even if the report is negative but suspicion strong refers the case to Peoples' Hospital 2. AFB slides to Peoples' Hospital for confirmation. 3. Diagnosis and prescribing treatment by doctor or when doctor visits at Sahayogini level. **Preventive and Promotive** Ensures BCG immunisation to every child in her community. Counselling to patients and family record of all the cases at 5000 level. **NON MEDICAL** **Health Communication** - Prepare pamphlets to create awareness on TB **Organisation** - Organises community to take BCG vaccine through Immunisation clinics or at school level.	**MEDICAL** **Curative** 1. Suspicious cases for confirmation. 2. AFB for confirmation 3. Treatment requires for TB patients. 4. Treatment of complicated cases **Preventive and Promotive** Rehabilitation of all the TB cases Ensures regular supply of BCG vaccination. **NON MEDICAL** **Health Communication** - Forwards statistics to Health Ministry. **Organisation** - Organises patients for lateral sharing to build positive outlook.

Gastro intestinal Problems - Watery Diarrhoea

Community Health	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Curative** elicit symptoms : presumptive diagnosis, Treatment with ORT, Home made preparation and Traditional medicine. Looks for sign and symptoms of dehydration. Refers Moderate dehydration or even after 36 hours if diarrhoea is not under control or severe vomiting. **Preventive and Promotive** Case to be reported to VHF. Monitors water purification at source **NON MEDICAL** **Health Communication** Informs community about purification of water at end point usage. Awareness about sanitary practices. Awareness that germs are present in water and can cause disease (use of school microscope to show germs) Awareness that viruses cannot be killed with Medicines. Disease is self limiting and given time, improves on its own. **Organisation** Organises the community for water purification at source.	**MEDICAL** **Curative** Assess moderate dehydration and if oral fluids are not tolerated - Ref to Sahayogini for IV. (Intravenous fluid therapy.) **Preventive and Promotive** Keeps a record of the case and finds linkages with socio-economic status, water supply or individual health practices, season etc and takes corrective measure. Analysis and sends the report to Sahayogini and discusses in lateral sharing meetings. **NON MEDICAL** **Health Communication** Informs community about purification of water at source. **Organisation** organises community for safe water supply and improved Sanitation facilities	**MEDICAL** **Curative** Treats severe dehydration, if needed with Intravenous/subcutaneous fluids. If condition does not improve after 2 hrs - Refers to Peoples' hospital. **Preventive and Promotive** 1. Chlorination of the well 2. Monitoring water testing and maintaining the report and corrective actions. **NON-MEDICAL** **Health Communication** 1. Preparing pamphlets with the help of VHF/CHF on diarrhoea and dehydration for awareness. 2. Updating CHF/VHF on diarrhoea. 3. Preparation of pamphlets on Diarhhoeal diseases. **Organisation** Dessiminates pamphlets for community organisation	**MEDICAL** **Curative** Treatment all complicated cases / severe dehydration. **Preventive and Promotive** Directs CHF, VHF and Sahayogini in treatment causes and rectifying measures. **NON-MEDICAL** **Health Communication** Plans for the awareness campaign at the block level. Training of CHF/VHFs and Sahayoginis. **Organisation** Plans for the block and co-ordinates with other government departments for safe water supply in the block and proper sanitation facility

• *The Preventive and Promotive and Non medical aspects may overlap*

Gastro intestinal problems - Acute abdomen

Community Health Functionary	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Curative** Suspects Intestinal obstruction : Pain in Abdomen, Green vomitting Suspects Acute Appendicitis : Fever, nausea or vomitting, Pain in right lower side of Abdomen. Suspects Ectopic Pregnancy : Sudden abdomenal pain with fainting attacks during early pregnancy. **Preventive and Promotive**	**MEDICAL** **Curative** Helps in Ref if Bowel Sounds are absent/ no improvement after Flatus tube passage Decides to transfer the patient to Peoples' Health Centre on emergency basis in semi Fowlers position. **Preventive and Promotive**	Arranges first-aid and transport to Hospital Using telecom and Sympmed --- ---	**MEDICAL** **Curative** Treating complicated cases
NON MEDICAL **Health Communication** - Awareness on danger singnals of Acute Abdomen and need to be at Peoples' Hospital for diagnosis and treatment. **Organisation** Organisation of the community for arranging transport in case of emergency.	**NON MEDICAL** **Health Communication** - Awareness and primary nursing training given to community members on caring patients; like ryles tube feeding, changing of sheet, steam inhalation etc. **Organisation** Organises community for taking care of the patient during hospitalisation.		

Pregnancy

Community Health Functionary	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Curative** - Suspects Pregnancy if missed period for 3 months - Treatment Minor disorder like morning sickness, Constipation, Weakness **Preventive and Promotive** - Advises mother on Diet, rest, exercise during pregnancy - Kitchen garden **NON MEDICAL** **Health Communication** - Awareness about major ailments of pregnancy and if needed to contact Health providers immediately. - Awareness about changes in pregnancy - Awareness about care of new born baby. - Promotes breast feeding **Organisation** Organise community to help poor pregnant woman with diet in form of giving her fruits and vegetables Organisation of the community to provide transport facilities in emergency	**MEDICAL** **Curative** Confirmation through following signs Breast changer, Hegar Sign and Jacqmier's Sign, Ossander's Sign Treat Hyperemesis gravidarum with home remedies and if no improvement in six hours refer to Sahayogini Dispenses and Ensures Fersolate and Folic acid Treatment - Identify High risk mother through history and examinations. 1. Short woman 2. Shoe size less than 4 3. Primipara below 18 or above 35 yrs. or Multipara with 4 or more children. 4. Victim of Domestic violence. **Signs** - Anaemia, Hypertension, Urine Albumin positive, Urine Sugar positive **Preventive and Promotive** Registration of pregnant woman Regular check up of pregnant woman for monitoring and referal Breast feeding **NON MEDICAL** **Health Communication** - Awareness on danger signals. **Organisation** Organise community to provide light work to pregnant woman in the field.	**MEDICAL** **Curative** - At least two check ups of a pregnant woman. - External pelvimetry to assess the normal size of pelvis and if not refer the case for delivery to Peoples' Hospital - Treat hypermesis gravidarum with IV fluids if condition does not improve within 8 hrs - Ref. **Preventive and Promotive** - Hb estimation Blood group and Rh antigen. Blood collection for VDRL and AIDS testing. - Estimates Risk and decides. whether to conduct delivery at village or at 5000 population center or at Peoples Health Centre. **NON MEDICAL** **Health Communication** - Prepare pamphlets on various aspects of pregnancy and its complications - Posters, pamphlets, films on breast feeding **Organisation** Organises community on gender issues.	**MEDICAL** **Curative** - VDRL and AIDS testing - Looks after the referral cases and if necessary providers reverse referral. - Conduct complicated labour cases. - Caesarian section if required. **Preventive and Promotive** - Counselling on unnecessary abortions - Judicious use of Ultra sonography **NON MEDICAL** **Health Communication** - Awareness on the use of Asceptic techniques during labour - training of CHFs/VHFs and Sahyogini for safe pregnancy and labour. **Organisation** Coordination with women and child department to provide help if required by pregnant woman.

Malaria

Community Health Functionary	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Curative :** Suspects Malaria if fever with rigors or any person suffering from unexplained fever should have her/his blood tested for Malaria. - Recognises signs and symptoms of Cerebral Malaria; headache, mental confusion, high fever, coma. **Preventive and Promotive** - Information given to people on how to protect themselves from mosquito bites - Looks for possible sources of Mosquito breeding and VHF is informed about need for DDT Spray. - Inform community about traditional ways of controlling Mosquitos. **NON MEDICAL** **Health Communication** * Informs community how Malaria is spread and preventive measures to be taken. **Organisation** * Organises community for controlling mosquito breeding. * Organises community with help of VHF in arranging transport for emergency	**MEDICAL** **Curative** * Prepares Malarial parasite smear on two slides and sends them to Ref.2 and Ref. 3 * Presumptive treatment with Chloroquine is dispensed. * If M P smear is positive Radical treatment is ensured. **Preventive and Promotive** * If required presumptive treatment is given to community in case of epidemics. * Helps community in making soak pits. * Arranges for DDT spray * If water body is large after discussion with people Gambusia fish is added. **NON MEDICAL** **Health Communication** - Inform linkages of development work with mosquito breeding sites like dams, canals etc. **Organisation** - Organises community for Mosquito control. - Arranges for transportation and informs peoples Hospital and Sahayogini that cerebral Malaria case is being transfered.	**MEDICAL** **Curative** M. P. smear is examined for Plasmodium and if positive, report is sent back to VHF for radical treatment. **Preventive and Promotive** Keep tracks of all the cases coming from her area. If cases are reported from a definite geographical area she looks for the possible breeding sources of mosquitoes and takes action. **NON MEDICAL** **Health Communication** If a new development activity is undertaken in her area, participates and makes sure every action is taken to inform people about the possible hazards of the activity and action to protect themselves. **Organisation** - Organises community to take action on any unwanted developmental activity and thus community can ensure protective measures from the activity .	**MEDICAL** **Curative** M P smear for confirmation. If the report pattern differs from Sahayogini and Ref. 3 on 3-4 smear. Training is provided to Sahayogini. Takes care of complicated cases like cerbral malaria. **Preventive and Promotive** - Ensures regular DDT supply - Looks for alternative harmless spray to control mosquitoes. **NON MEDICAL** **Health Communication** - Informs people and government officials about linkages of developmental activity with increase in malaria cases. **Organisation** - Coordinates different government departments and participates in different government programmes to ensure that any new activity which will be taken up will be informed to Peoples' Health Centre and thus corrective measures can be taken.

Family Planning

Community Health Functionary	Village Health Functionary	Sahayogini	Peoples' Hospital
MEDICAL **Preventive and Promotive** 1. Selects eligible couples from her community. 2. Discusses with them their priorities and when would they like to have a child or the subsequent children. 3. Discusses pros and cons of various family planning methods with eligible couples. 4. Hands out Mechanical Barrier for spacing like condoms and diaphrams.	**MEDICAL** **Curative** Eligible couples referred to her for regular distribution of oral contraceptives. Examines and enquires about the side effects like headache, nausea, spotting etc. refers to Sahayogini **NON MEDICAL** **Health Communication** - Informs and discusses with villagers regarding male responsibility in Family Planning. - Informs villagers of linkage of poverty and having children. **Organisation** - Organises community for lectures from experts on various F.P. methods especially on vasectomy.	**MEDICAL** **Curative** Medical check up of women coming for oral contraceptives and Intra-uterine device. Inserts IUDs and monitors and follows up the cases. Periodic check up of Oral Contraceptive users by visiting doctor yearly. **NON MEDICAL** **Health Communication** Encourages couple for permanent sterlisation tubectomy/ vasectomy at appropriate time.	**MEDICAL** **Curative** - Handles all complicated cases of IUD and Oral Contraceptive. - Tubectomies/vasectomies are perfomed. **NON MEDICAL** **Health Communication** - Discusses with husband about male responsibility in Family Planning and counselling is performed for vasectomy.

Community Health Functionary 200 Population (35-50 Households)

Selection	Training	Functions	Facility Required	Communication
* Female * Acceptance by family and Community * Motivated * Reading and writing skills (4/5th Std.) * Preferably daughter in law * Permenant resident of the village * Has spare time	**INITIAL TRAINING** In Village for 25 days on alternate days * Consists of theoretical, practical and hands on training **CONTINUOUS TRAINING** * Continuous training, contact sessions per month for a day. * Lateral sharing at 5000 population monthly. * Hands on training by VHF, Sahayogini and Doctors while visiting and during contact sessions.	**MEDICAL** **Preventive and Promotive** - Preventive and promotive aspects listing of children for Immunisation, planning and making of soak pits, simple latrines, purification of water at end source. - Monitoring Growth of child. - Early registration of pregnancy - Exercise classes Nutritional Advice **Curative :** *Diarrhoea, Fever, ARI, minor aches and pains, Dressing of minor injuries . - Suspects Major illnesses such as TB, Leprosy, Malaria etc. - Assuring regularity of treatment in case of TB, Leprosy (DOTS) etc. **NON-MEDICAL** * **Health Communication** on - Awareness of Danger Signals and use of graded referral. - Information regarding soak pits, latrines and water purification, kitchen garden and herbal medicines. * **Organisation of the community** for water purification, Soak pits, Simple Laterine, Maintenence of water Pipes, Smokeless Chullas, Repair of hand pumps, Chlorination -well - home	**MEDICINE KIT** **Home remedies e.g.** Ginger, garlic, Nutmeg, Clove, *Murudsheng,* Dalchini, Turmeric, Belphal, Ajwain, Sugar, Salt Baking Soda. **Ayurvedic e.g.** Sanjivani Vati, Jwar guti **Allopathic e.g.** Paracetamol, Cotramexazole **Homeopathy e.g.** Arnica, Aconite, Chamollia, China, Sulphur **Biochemic e.g.** No. 5 and 6 **TEACHING AIDS** * Posters * Flipcharts * Black Board **Administration and Accounts** * Maintaining Receipt Book for Accounts * Maintaining Records	*Oral Communication * No transport required for commuting

● *The Preventive and Promotive and Non medical aspects may overlap*

Village Health Functionary - 1000 to 2000 Population

Selection	Training	Functions	Facility Required	Communication
* Same as CHF with basic mathematical skills	* Six months theoratical, practical and hands on training. * Two months at Peoples' Health Centre and four months with Sahyogini. * Lateral sharing once a month for a day at Sahyogini level. * Contact sessions for three days every six months at Peoples' Health Centre	**MEDICAL** **Preventive and Promotive** * Preventive - administrating of Immunisation, Conducting ANC clinics * Promotive - knowledge of soak pits, laterines, DDT spray, Water purification, Hand pump repairs and help CHF in making them. * Organisation of villages for preventive aspects * **Curative** - treatment of Malaria, tonsilitis, worm infestation, Gastritis, Scabies, Dysentry, Dysmenorrhoea, Leucorrhoea, Examination of ante-natal cases and conducting normal deliveries. Care of post-natal mothers, Care of new born * First aid * Drug management skills - Information on which drug and when to indent * Takes MP slides, Urine for Alb and sugar, blood pressure, Collection of sample for sputum . * Can administer Methargine Injections. * Maintain records of cases **NON-MEDICAL** * Organisation of villages for preventive aspects * Maintain records of cases * Training of 4 - 5 CHF in her village	* Three rented room for treatment, stores and office. * Cooker (Autoclave) * Gloves * Syringes and needles * Delivery packet * Dressing kit * Sphygmomanometer * Medicine kit as mentioned in CHF with additional drugs, **Allopathy** Amoxicilline, Domperidon Antacids, Metronidazole, Mebendazole, Salbutamol, Gynaec CVP, Benzyl Benzoate, **Ayurvedic medicines** Kuda parpatika, Sutshekhar, Triphala Churna, Nag Keshar. **Homeopathy** Ipeac, China, Antimonium, Tart * Hand sets * Splints * Forms and registers * Stationery	* Oral * Transport by ST bus, Available local transport * Public phone

● *The Preventive and Promotive and Non medical aspects may overlap*

Sahyogini - 5000 to 7000 Population

Selection	Training	Functions	Facility Required	Communication
* Local Women * Can devote minimum of 8 hours per day * Standard 10th	* 2 years - 1st year at village level with Higher secondary School 2nd year at Peoples' Health Centre and with higher secondary school * Continuous training in the form of lateral sharing at Peoples' Health Centre. Six days every year at Peoples' Health Centre. * Monthly Newsletter and Manuals a)Epidemiology b) Basic knowledge of human body and its functions c) Minor and Major diseases d) Record keeping.	**MEDICAL** **Preventive and Promotive** * Exercises and Diet Control * Epidemiologic surveillance * Councelling * Recording of morbidity and mortality in the area and plan accordingly. **Curative** * Laboratory Techniques - Hb estimation, AFB slides, Malarial parasite smear, Urine culture and sensitivity, Collection of throat swab, Water analysis, Stool examination, Blood grouping, Rh factor, Collection of blood for VDRL and AIDS and LFT. * Curative same as VHF. Conducting normal delivery Primipara Intravenous fluid detecting vision disorders, Suturing, Low Forceps * Treatment for TB and Leprosy by a doctor * Oxygen therapy **NON-MEDICAL** * Training of CHF and VHF. * Preparation of Training material - Mannuals and Newsletters, Posters, Flip charts	* Seven rooms on rental basis - A laboratory, a clinic, delivery room, in-patient room, Store, Office room, Teaching centre. * Sutures * Episiotony scissors * Low Forcep * Microscope * Centrifuge * Incubator * Autoclave * Bleaching powder * Herbal garden * Nursery * Cyclostyling machine * Tools required for repair and maintenance of handpumps * Information on other government officers and Panchayat members and government schemes for coordination. **Medicines :** * Methargine, Leprosy and TB drugs, Local Anaesthestic, Brufen, Plaster of Paris	* Telecommunication Base station with computers and Symptomatic Medicine package * Use of local transport, Two wheeler can be provided. *Intersectoral Communication and coordination

- *The Preventive and Promotive and Non medical aspects may overlap*

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